(1)

# 91-1946

Supreme Court, U.S.
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No. _____

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1992

STATE OF OKLAHOMA ex rel.
DEPARTMENT OF HUMAN SERVICES

Petitioner,

v.

TRUST COMPANY OF OKLAHOMA, guardian
of the estate of Ellen Lee Barker,
a minor child,

Respondent.

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED FOR REVIEW

1. Whether a trust, created for the primary purpose of providing non-medical support but allowing for the payment of medical care if the beneficiary became ineligible for medical assistance, is an "available resource" under the Medicaid Act, 42 U.S.C. § 1396a (17)(B).

2. Whether the grantor of a trust may specifically exclude assets of a trust from consideration by a state as a "resource" under the Medicaid Act, 42 U.S.C. § 1396a (17)(B) and whether state law controls the definition of "resources" under the Medicaid Act.

3. Whether the application of the Oklahoma Supreme Court's state procedural waiver rule improperly precluded the application of federal law in considering the income from a state-created trust in the determination of Medicaid eligibility under 42 U.S.C. § 1396a (17)(B).

4. Whether an inter vivos trust agreement between a tortfeasor and the guardian of the estate of a minor child constitutes a "Medicaid Qualifying Trust" under the terms of Medicaid Act, 42 U.S.C. § 1396a(k).

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## OPINIONS DELIVERED IN STATE COURTS BELOW

The opinion of the Oklahoma Supreme Court is reported in Trust Co. of Oklahoma v. State ex rel. DHS, 825 P.2d 1295 (Okla. 1991), and was filed on December 17, 1991. The opinion is contained in appendix 3.

## GROUND UPON WHICH JURISDICTION IS INVOKED

The judgment of the Oklahoma Supreme Court was dated December 17, 1991. Timely rehearing was sought by the Oklahoma Department of Human Services (hereinafter referred to as "DHS") on January 27, 1992. Rehearing was denied on March 4, 1992.

The jurisdiction of this Court is predicated under 28 U.S.C. § 1257(a).

## CONSTITUTIONAL AND STATUTORY PROVISIONS

U. S. Const. Art. VI, Cl. 2:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

The Medicaid Act and particularly 42 U.S.C. § 1396a (17)(B) as well as DHS's regulations regarding resources under the

Medicaid program has been reprinted in its entirety. See App. at 1 & 2 respectively.

## STATEMENT OF THE CASE

In 1980, Ellen Barker, a minor child, was severely injured in an auto accident. While traveling in Arizona, the Barkers' car was struck by a school bus operated by the Ganado School District. She was rendered a quadriplegic as a result of the accident and filed suit against the Arizona school district. A settlement of $1,346,175.00 was made between the Barkers and the school district. After a deduction of costs from the settlement proceeds, Ellen Barker received $818,940.00.

At the time of settlement, the parents of Ellen Barker requested an Oklahoma Court to appoint the Trust Company of Oklahoma as

the guardian of the estate of Ellen Barker.[1] The Court granted this request and on May 22, 1981, the settlement proceeds were distributed and a trust agreement was executed. The trust agreement was executed between two private parties: the Ganado School District and the Trust Company of Oklahoma.

The "Declarations and Definitions" section of the trust agreement provided in pertinent part:

> A. Purposes:
>
> . . .
>
> Ellen has been hospitalized since the accident and will continue to be hospitalized or institutionalized in Oklahoma City for an indefinite period of time. Ellen's medical needs have been provided for by the Oklahoma Department of Human Services; however,

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[1] The parties to this litigation are those which appear in the style of the case; namely, the State of Oklahoma, Department of Human Services and the Trust Company of Oklahoma who is the guardian of Ellen Barker's estate.

> in addition to her medical needs, Ellen will need special care throughout her lifetime, in order for her to live as normal and productive a life as possible under these circumstances. The primary purpose of this trust, therefore, is to furnish Ellen, during her lifetime, with the nonmedical equipment, care, education, training, rehabilitation, entertainment, transportation, or assistance which she will need to assure her of as natural and pleasant a life as is possible in her condition. If, for any reason, Ellen ceases to qualify for medical assistance, then the trustee may in its discretion, also provide any medical assistance which Ellen may require.

In addition to the purpose of the trust, the trust agreement outlined the terms of payments of both the trust income and principal. The agreement provided in pertinent part:

> A. Income Payments. During the life of the primary beneficiary, trustee may pay the net income of the trust estate at such times, in such amounts, and in such manner as trustee deems best, in the absolute discretion of trustee, in accordance with the purposes set forth in Article I of this trust agreement, for the direct or indirect benefit of the primary

beneficiary, taking into consideration, however, all other sources of income available to the primary beneficiary.

. . .

B. Principal Payments. During the life of the primary beneficiary, trustee may pay the principal of the trust estate at such times, in such amounts, and in such manner as trustee deems best, in the absolute discretion of trustee, for the maintenance, support, health, and education of the primary beneficiary, taking into consideration, however, other resources available from third parties to provide for the maintenance, support, health, and education of the primary beneficiary.

After the trust was executed, Ellen Barker was hospitalized at the Oklahoma Children's Memorial Hospital from 1981 to 1986. During this time period, she remained eligible under the Title XIX program.

In late 1985, Ellen Barker's mother reported the trust to a county social worker of DHS in a re-application for medical assistance. During 1986, DHS discovered

that Ellen Barker had received $800.00 per month from the trust and $3,000.00 was paid to the Barker family from the trust for Ellen Barker's benefit. Based upon the receipt of these monies and the assets in the trust itself (which had grown from $818,000.00 to 1.2 million dollars) DHS terminated Ellen Barker's Medicaid case.[2]

After the termination of the Medicaid case, DHS continued to pay for some medical

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2

It should be noted that a point of contention throughout the litigation was DHS's knowledge of the trust agreement and whether DHS was estopped to consider the assets of the trust. A DHS attorney was involved in the collection of monies from the estate based upon Medicaid's payment of medical bills prior to settlement. See 42 U.S.C. § 1396a (25). However, between 1981 and 1986, no documents regarding this trust could be found. At the state court level, the respondent continually argued the state was estopped to consider the assets of the trust based upon DHS's presence in the case at its outset. The petitioner argued that the DHS official was without any authority to agree to ignore the trust from consideration as a resource.

supplies under another federal-state program called the Crippled Children's Program (CCP). DHS followed this course while it discussed with the Trust Company how to resolve the matter. In May, 1987, DHS terminated all medical assistance under both Medicaid and CCP programs. At that time, both programs had the same qualifications.

In June, 1987, the Trust Company appealed the decision of DHS to terminate assistance under both programs to the DHS Administrative Appeals Committee. A hearing was held on September 10, 1987, and the Appeals Committee rendered a decision on February 12, 1988. The Appeals Committee affirmed the decision of DHS on the basis of the value of the trust exceeded the resource limitation under the Medicaid and CCP programs of $1,700.00.

The Trust Company appealed the final administrative decision of the agency in

March, 1988, to state district court. The state district court reversed the decision of DHS on October 5, 1989, finding DHS's decision was clearly erroneous because it was estopped from asserting that the trust is now an available resource. DHS then appealed this decision to the Oklahoma Supreme Court which assigned the case to the Oklahoma Court of Appeals, one of the state's civil appellate courts. At this stage in the proceeding, DHS raised the issue of whether a trust was a resource. See App. at 3. DHS also raised the issue of the Medicaid Qualifying Trust arguing that DHS was not estopped to consider the trust as a resource. See App. at 3. The Oklahoma Court of Appeals, Division III, reversed the decision of the state district court after finding that the doctrine of estoppel had no application where a state employee's acts were beyond the scope of employment.

After the Court of Appeals' decision, the Trust Company appealed this decision to the Oklahoma Supreme Court. The Oklahoma Supreme Court considered the case by certiorari.

On December 17, 1991, the Oklahoma Supreme Court decided the case. The Court found the state had waived any argument regarding consideration of income from the trust. See App. at 4. The basis for the waiver was the Court's procedural rule regarding certiorari. The Court also found that the majority of other jurisdictions had ruled that discretionary trust assets were not resources under the Medicaid Act. The Court found that because the grantor of the trust was the tortfeasor, and not the beneficiary, the trust was not a Medicaid Qualifying Trust under 42 U.S.C. §1396a(k). Finally, the Court found that "Because, absent a conflict with a principle of law,

interpretation of a trust's terms are controlled by the settlor's intent, we find the reasoning of the majority persuasive." Trust Co. of Oklahoma v. State ex rel. DHS, 825 P.2d 1295, 1303 (Okla. 1991). As stated by the Oklahoma Supreme Court, the reasoning of the majority of other jurisdictions was that the settlor's intent must be given affect. If the settlor intended to supplement rather than supplant public financial assistance then these assets were not resources under the Medicaid Act. Ibid.

DHS requested rehearing on January 27, 1992. At this stage of the proceeding, DHS raised the Supremacy Clause argument. See App. at 3. The reason this issue was not raised until rehearing is twofold. First, until the time the Oklahoma Supreme Court decided the case, the predominant issue was estoppel. Second, under Oklahoma Appellate Court rules, briefing is not permitted on

review by certiorari. 12 Okla.Stat. 1991, Ch. 15, App. 3, Rule 3.15. DHS was not aware on certiorari the Court would rely upon state law in the manner it did.

The Oklahoma Supreme Court denied rehearing on March 4, 1992.

## REASONS FOR GRANTING THE WRIT

1. **THE STATE COURT BELOW HAS INTERPRETED A FEDERAL STATUTE OF CONSIDERABLE IMPORTANCE IN THE MEDICAID ACT. THE DECISION BELOW CONFLICTS WITH OTHER DECISIONS OF STATE COURTS OF LAST RESORT REGARDING THE SAME STATUTE, THE DECISION VIOLATES THE SUPREMACY CLAUSE OF THE UNITED STATES CONSTITUTION AND THE DECISION ERRONEOUSLY EXPANDS THE MEDICAID ACT BY RELIANCE UPON STATE LAW.**

A. **THE COURT BELOW HAS INTERPRETED A FEDERAL STATUTE OF CONSIDERABLE IMPORTANCE UNDER THE MEDICAID ACT AND ITS INTERPRETATION CONFLICTS WITH OTHER DECISIONS OF STATE COURTS OF LAST RESORT REGARDING THE SAME STATUTE.**

The issue in this case is a simple one but it profoundly affects both state and federal governments in their implementation

of the Medicaid program. At the core of the Act is the responsibility of the single state agency to count "resources" and "income" of an applicant for assistance to determine their eligibility for services. The Medicaid Act provides in pertinent part, "A state plan for medical assistance must - . . . include reasonable standards for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter (B) provide for taking into account only such income and resources as are . . . available to the recipient . . . as would not be disregarded in determining his eligibility for such aid, assistance and benefits, (C) provide for the reasonable evaluation of any such income and resources, . . . .

The Oklahoma Supreme Court has decided that a 1.2 million dollar discretionary non-

medical trust is not a "resource" under the Medicaid Act. The basis of this decision was that under state trust law, a grantor may express his or her intent to shelter assets given to a beneficiary to exclude the assets as countable resources.

This issue has been debated in many state courts and courts of last resort throughout the nation have decided the issue in a conflicting manner. In the case of In the Matter of Welfare of K.S., 427 N.W.2d 653, 658-59 (Minn. 1988), the Supreme Court of Minnesota decided a state statutorily created trust for minors consisting of personal injury settlement funds was a resource under Minnesota's State Medicaid Plan.

Similarly, in the case of Arkansas Dep't. of Human Servs. v. Donis, 280 Ark. 169, 655 S.W.2d 452 (1983), the Supreme Court of Arkansas considered whether the

assets of a court created trust for a family as a result of a wrongful death suit was a resource under the Medicaid Act. The court found the trust assets were resources and reversed the decision of a lower court.

While basing its decision on a different ground, the Hawaii Supreme Court has also decided this issue contrary to the Oklahoma Supreme Court. In the case of Barham v. Rubin, 816 P.2d 965 (Hawaii 1992) the Hawaii court found that an incompetent's probate court trust created from a personal injury settlement was a Medicaid Qualifying Trust (MQT) under 42 U.S.C. § 1396a(k). The MQT statute requires that the grantor possibly be a beneficiary. Despite the fact that in Barham, supra, the probate court was the grantor, the court found the MQT recipient was the constructive grantor of personal injury settlement funds and the recipient was the beneficiary of the trust.

In direct contrast to these cases, and in agreement with the Oklahoma Supreme Court's decision, several courts have found that trusts are not resources under the Medicaid Act and given the same facts as this case were not Medicaid Qualifying Trusts. For example, in the case of Zeoli v. Commissioner of Social Servs., 179 Conn. 83, 425 A.2d 553, 556-59 (1979), the Supreme Court of Connecticut considered whether a testamentary spendthrift trust which was totally discretionary was an available resource under Medicaid. The court found the assets were not resources reasoning that under state trust law the testator wanted his assets to provide supplemental support only. Further, the court found the assets not available because the testator expressed this intent in his trust.

Similarly, in the case of Jansen v. Department of Pub. Welfare, 201 Neb. 185,

266 N.W.2d 742, 745 (1978), the Nebraska Supreme Court held that the assets of a discretionary trust were not resources in an application for Nebraska's aged, blind and disabled program.

In the case of Miller v. Ibarra, 746 F. Supp. 19, 26 (D. Colo. 1990), the federal district court for the District of Colorado held that inter vivos discretionary trusts were not resources and that these trusts were not Medicaid Qualifying Trusts because the grantor (the probate court) could not be the beneficiary. While this case was not a state court decision, it demonstrates the conflict with regard to decisions regarding MQT's.

There are a number of other appellate and trial court cases in other states which are also in conflict. Compare Commonwealth Bank & Trust v. Department of Pub. Welfare, 128 Pa. Commw. 528, 563 A.2d 1299 (1989);

Stoudt v. Commonwealth Dept. of Public Welfare, 76 Pa. Commw. 576, 464 A.2d 665-66 (1983); Harrington v. Blum, 458 N.Y. Supp. 2d 864, 117 Misc. 2d 623 (N.Y. App.Div. 1982) (all holding discretionary trusts are resources under Medicaid) with Lang v. Commonwealth, 515 Pa. 428, 528 A.2d 1335, 1345 (1987); Kline v. Utah Dept. of Health, 776 P.2d 57, 63 (Utah Ct. App. 1989); Lineback v. Stout, 79 N.C. App. 292, 339 S.E. 2d 103, 108 (Ct. App. N.C. 1986); Tidrow v. Director, 688 S.W. 2d 9, 13 (Mo. Ct. App. 1985) (all holding discretionary trusts are not resources under Medicaid).

Based upon the cases cited above, it is clear that states are divided on this issue.

The importance of this issue may not be as clear. Because the Medicaid program is a federal program administered in all 50 states, there should be a uniform rule regarding whether trust assets are

resources. As it stands now, courts are deciding cases on a case-by-case basis because there is no precise federal statutory or regulatory guidance. This case-by-case determination not only slows the eligibility process but the states also expend excessive litigation costs in having courts determine in each case whether a trust is a resource. While it is true that every trust instrument is factually dissimilar, the meaning of resource should not be dependent upon the intent of the grantor. It should be dependent upon what "resource" means under federal law.

### B. THE DECISION VIOLATES THE SUPREMACY CLAUSE OF THE UNITED STATES CONSTITUTION

The purpose of the Supremacy Clause of the United States Constitution is to prevent conflicts which would follow if the federal government's general authority were subject

to local controls. United States v. Alleghany, 322 U.S. 174, 183, 64 S. Ct. 908, 913, 88 L.Ed. 1209 (1944). In some areas of law, including property law, states may regulate as long as there is no conflict with federal law. Cf. United States v. Burnison, 339 U.S. 87, 94, 70 S.Ct. 503, 507, 94 L.Ed. 675 (1950) with Kolourat v. Oregon, 366 U.S. 187, 196-197, 81 S.Ct. 922, 927-928, 6 L.Ed.2d 218 (1961).

In the case of Hisquierdo v. Hisquierdo, 439 U.S. 572, 99 S. Ct. 802, 59 L.Ed.2d 1 (1979), this Court used the preemption doctrine to strike down a California family law provision, because it conflicted with a provision of the Railroad Retirement Act of 1974. While this Court recognized that the area of family law belonged to the state it stated:

> On the rare occasion when state family law has come into conflict with a federal statute, this

> Court has limited review under the Supremacy Clause to a determination whether Congress has "positively required by direct enactment" that state law be pre-empted. A mere conflict in words is not sufficient. State family and family-property law must do "major damage" to "clear and substantial" federal interests before the Supremacy Clause will demand that state law be overridden.

Hisquierdo v. Hisquierdo, 439 U.S. 581, 99 S.Ct. at 808 (1979).

Using the test enunciated in the above referenced case, the Supremacy Clause is implicated in the present case. Because of the presence of this issue, the Court should accept this case.

In volumes of statutes, regulations and instructions by the Health Care Financing Administration, the Medicaid Act regulates how states implement a nationwide medical assistance program for the needy. This Court has acknowledged its broadness and its complexity, stating its Byzantine

construction makes the Act almost unintelligible to the uninitiated. Schweiker v. Gray Panthers, 453 U.S. 34, 43, 101 S. Ct. 2633, 2640, 69 L.Ed.2d 460 (1981). The complexity of the law demonstrates Congress's intent to fully regulate the program. Furthermore, Congress has explicitly mandated that states take into account available resources.

Against the backdrop of the Medicaid Act, there lies the area of property law and more specifically, the law of trusts. One of the predominate rules in the areas of trusts which is stated by many state court decisions labelling a trust as an "unavailable resource" is that the interpretation of a trust's terms are controlled by the settlor's intent. Trust Co. of Oklahoma v. State ex rel. DHS, 825 P.2d 1295, 1303 (Okla. 1991). See also Chenot v. Bordeleau, 561 A.2d 891, 894 (R.I.

1989); Lang v. Commonwealth, 515 Pa. 428, 528 A.2d 1335, 1345 (1987); Zeoli v. Commissioner of Social Servs., 179 Conn. 83, 425 A.2d 553, 556 (1979); Lineback v. Stout, 79 N.C. App. 292, 339 N.E. 2d 103, 108 (N.C. App.1986); Tidrow v. Director, 668 S.W. 2d 9, 12 (Mo.Ct.App.1985); Hoelzer v. Blum, 462 N.Y.S.2d 684, 689 (N.Y.App.Div.1983).

These two laws, the Medicaid Act's prescription to take into account "available resources" and the use of the settlor's intent to define access to the trust, conflict in this case. First, as a general rule of statutory construction, the words used by Congress must be presumed to have some meaning. See Pennsylvania Dep't of Pub. Welfare v. Davenport, ____ U.S. ____, 110 S.Ct. 2126, 2130, ____ L.Ed.2d ____ (1990). Then, despite the fact that there are no federal regulations in the Medicaid Act which tell states how to assess a trust

as a resource, it must be presumed that Congress intended some objective definition of "available resource." Without a definition, Congress would have simply told states they had discretion to define the term. With some definition intended by Congress, the Oklahoma Supreme Court has allowed one grantor of a trust to define the term "available resource." The Court below has made this ruling by stating that the grantor may intend to supplement his assets with public assistance and this intent, by itself, makes the assets unavailable. Petitioner respectfully submits that allowing grantors of trusts to decide what resources are available is contrary to any definition Congress may have meant when 42 U.S.C. § 1396(a)(17) was passed. It cannot be that one single person, a grantor, in each different trust can decide the

availability of assets in a trust thereby thwarting Congressional intent.

A second reason a conflict is created between the state law and the federal statute is Congress's pronouncement in the Medicaid Qualifying Trust provision found in 42 U.S.C. § 1396a(k). In passing this statute, Congress stated:

> The committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves. When affluent individuals use Medicaid qualifying trusts and similar "techniques" to qualify for the program, they are diverting scarce Federal and State resources from low-income elderly and disabled individuals, and poor women and children. This is unacceptable to the Committee.

House Committee's Report No. 265, 99th Cong. 1st Sess. at 72, 1986 amendment of 42 U.S.C. § 1396a(k).

It is clear from this excerpt that Congress's intent in passing this statute

was to prevent those having discretionary trusts to use them to shelter their monies to make them eligible for assistance.

Completing the Hisquierdo v. Hisquierdo, 439 U.S. 581, 99 S. Ct. 808 (1979) analysis, this conflict will do major damage to clear and substantial federal interests. The intent of the Medicaid program is to assist those who are financially needy. The result of allowing grantors of trusts, to determine whether trust assets are available as resources for public assistance will simply divert already scarce federal dollars away from those who are financially needy. While it cannot be stated that a large percentage of DHS's caseload is made up of individuals with trusts, it can be stated that since the decision below was pronounced several persons have designed non-medical trusts simply to become eligible for medical

assistance. In each case, the medical costs of the case are staggering, as they are in the case at bar.

In conclusion, the Supremacy Clause is implicated in this case because of the conflict between the decision of the Court below and the Medicaid Act and this Court should grant certiorari to consider the case.

### C. THE DECISION ERRONEOUSLY EXPANDS THE MEDICAID ACT BY RELIANCE UPON STATE LAW

In the case of Schweiker v. Gray Panthers, 453 U.S. 34, 101 S. Ct. 2633, 69 L.Ed.2d 640 (1981), this Court interpreted the word available resources when construing whether the "deeming" of income between spouses was appropriate. While the issue in this case is not precisely similar, in Schweiker, supra, this Court took the opportunity to define "available" and stated that the word did not mean "in hand." This

Court took the opportunity to define "available" and stated that the word did not mean "in hand." This Court also stated that the State of Virginia was permitted to include resources over and above those actually paid. Schweiker v. Gray Panthers, 453 U.S. 48, 101 S. Ct. 2642, (1981). The significance of these statements is that the word available in 42 U.S.C. § 1396 a(17) does not mean actually paid or liquidated. This Court's holding conflicts with the decision below because the Oklahoma Supreme Court defined the word available to mean "in hand" or the amount of assets which could be converted to cash.[3]

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[3] The Schweiker, supra, holding also supports the proposition that Congress had some objective definition of available resource when it passed 42 U.S.C. § 1396a(17)(B).

## CONCLUSION

This Court should grant certiorari in this case. The State Court below has interpreted a federal statute of considerable importance in the Medicaid Act. The decision below conflicts with other decisions of state courts of last resort regarding the same statute. The decision below also violates the Supremacy Clause and the decision erroneously expands the Medicaid Act by reliance upon state law.

Respectfully submitted,

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# APPENDIX I

## 42 U.S.C. §1396a

## MEDICAL ASSISTANCE PROGRAMS

**§1396a. State plans for medical assistance**
**(a) Contents**

A State plan for medical assistance must--

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with

such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee

is prohibited by section 207 or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide--

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this

title or paragraphs (13) and (14) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to--

(i) all individuals-

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37), 606(h), or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family;

(V) who are qualified family members as defined in section 1396d(m)(1) of this title;

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),
(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,
(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,
(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;
(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of

the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;

(VIII) who is a child described in section 1396d(a)(i) of this title--

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1) of this section; or

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Secretary under section 1382e or 1383c of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available

to individuals not described in subparagraph (A);
(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then--
(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--
(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and
(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);
(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and
(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (21) of such section;
(D) for the inclusion of home health services for any

individual who, under the State plan, is entitled to nursing facility services; and

**(E)(i)** for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

**(ii)** for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individual]s described in section 1396d(s) of this title; and

**(iii)** for making medical assistance available for medicare cost sharing described in section 1396(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in section 1396a(u)(1) of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under Part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individual]s, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to

individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing. or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396o(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption. (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive

hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396o(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included

under subsection (e)(9)(A) of this section, provided such serves are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r-4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals and (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, and (XI) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State Plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title, and (C) provide for coordination of the operations under this subchapter with the State's operations under the special supplemental food program for women, infants, and children under section 1786 of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide--

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually

received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title;

(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of

determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of--

(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);

(D) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if

he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; for payment

**(E)** for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 13951(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 13951(a)(3) of this title; and

**(F)** for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;

**(14)** provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title;

(15) Repealed. Pub.L. 100-360, Title III, § 301(e)(2)(C), as added by Pub.L. 100-485, Title VI, § 608(d)(14)(I)(iii), Oct. 13, 1988, 102 Stat. 2416.

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments

under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or other wise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to

liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases---

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as maybe necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there

will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State Plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public

institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

**(23)** except as provided in subsection (g) of this section and in section 1396n of this title and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as maybe necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide--

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan, including--

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall--

(I) be integrated with, and be monitored as a part of the Secretary's review of the State's mechanized

claims processing and information retrieval system under section 1396b(r) of this title, and

(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount

which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall-

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency

under part D of subchapter IV of this chapter, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B); and

(G) that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide--

(A) with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person

receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide--

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and

services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of--

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services

are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;

(B) provide, under the program described in subparagraph (A), that--

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not. except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample maybe of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and

(II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases; and

(C) use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide--

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each intermediate care facility for the mentally

retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that--

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is

required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment; and

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an

informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services.

(33) provide--

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the

Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this

title) receiving payments under such plan complies with the requirements of section 1320a.3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to

the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a-7(b)(9) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 of this title or section 1320a-7a of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7),the State medical licensing board of such action;

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

(43) provide for--

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by

basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year,

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan--

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in

the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertified, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46) provide that information is requested and exchanged for purposes of

income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title;

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1396r-1 of this title;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r-2 of this title;

(50) provide, in accordance with subsection (q) of this section, for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51)(A) meet the requirements of section 1396r-5 of this title (relating to protection of community spouses), and (B) meet the requirement of section 1396p(c) of this title (relating to transfer of assets);

(52) meet the requirements of section 1396r-6 of this title (relating to extension of eligibility for medical assistance);

(53) provide--

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women,

breastfeeding or postpartum women (as defined in section 1786 of this title), or children below the age of 5, of the availability of benefits furnished by the special supplemental food program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54)(A) provide that, any formulary or similar restriction (except as provided in section 1396r-8(d) of this title) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1396r-8(a) of this title, which are prescribed for a medically accepted indication (as defined in subsection 13961-8(k)(6) of this title), and

(B) comply with the reporting requirements of section 1396r-8(b)(2)(A) of this title and the requirements of subsections (d) and (g) of section 1396r-8 of this title: and

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section--

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV of this chapter and which include facilities defined as disproportionate share hospitals under section 1396r-

4(a)(1)(A) of this title and Federally-qualified health centers described in section 1396d(l)(2)(B) of this title, and

(B) using applications which are other than those used for applications for aid under such part.

(55) provide, in accordance with subsection (s) of this section, for adjusted payments for certain inpatient hospital services.

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1396b(m)(1)(A) of this title) receiving funds under the plan shall comply with the requirements of subsection (w) of this section;

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w) of this section; and

(58) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (v) of this section) of all physicians who are certified to participate under the State plan.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this

subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph(10)). The provisions of paragraphs(9)(A),(31), and (33) and of section 1396b(i)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under

subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan maybe waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of paragraph(1) or(2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV of this chapter in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.

**(b) Approval by Secretary**

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan--

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

**(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance**

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if--

(1) the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

(2) the State requires individuals described in subsection (1)(1) of this section to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this subchapter.

**(d) Performance of medical or utilization review functions.**

If a State contracts with an entity which meets the requirements for section 1320c-1 of this title, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C) of this section, or a utilization and quality control peer review organization having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review function (including quality review functions described in subsection (a)(30)(C) of this section) required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by an entity or organization as the Secretary may prescribe.

**(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women**

(1)(A) Notwithstanding any other provision of this subchapter, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on September 30, 1998. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved underpart A of subchapter IV of this chapter and have earned income, see section 1396r-6 of this title.

(2)(A) In the case of an individual who is enrolled with a qualified health

maintenance organization (as defined in Title XIII of the Public Health Service Act [42 U.S.C.A. § 300e et seq.]) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title under a contract described in section 1396b(m)(2)(A) of this title or with an eligible organization with a contract under section 1395mm of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph(B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only with respect to such benefits provided to the individual as an enrolle of such organization or entity.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who--

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that--

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter, shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively,is being paid under subchapter XVI of this chapter.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance

eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

**(5)** A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

**(6)** In the case of a pregnant woman described in subsection (a)(10) of this section who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) of this section and subsection (l)(1)(A) of this section without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r-1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (1)(1) of this section or paragraph (2) of section 1396d(n) of this title--

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who--

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph. respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV of this chapter pursuant to section 602(a)(43) of

this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

**(B)** If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV of this chapter and such aid is terminated pursuant to section 602(a)(43) of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

**(11)(A)** In the case of an individual who is enrolled with a group health plan under section 1396e of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)),the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrolle of such plan.

**(B)** For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of

not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

**(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals**

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section and section 1382h(b)(3) of this title and section 1396r-5 of this title, except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this

title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible

for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

**(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions**

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C) of this section.

**(h) Payment adjustments with respect to hospitals serving disproportionate number of low-income patients with special needs and for home and community care**

Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this subchapter with respect to hospitals that serve a disproportionate number of low-income patients with special needs or to limit the amount of payment that may be made under a plan under this subchapter for home and community care.

**(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for mentally retarded**

(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

**(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa**

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(c) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the

Northern Mariana Islands for care and services described in paragraphs (1) through (22) of section 1396d(a) of this title.

**(k) Treatment of potential payments from medicaid qualifying trusts**

**(1)** In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17) of this section, is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term "grantor" means the individual referred to in paragraph (2).

**(2)** For purposes of this subsection, a "medicaid qualifying trust" is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

**(3)** This subsection shall apply without regard to--

**(A)** whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for

medical assistance under this subchapter; or

**(B)** whether or not the discretion described in paragraph (2) is actually exercised.

**(4)** The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship.

**(1) Description of group**

(1) Individuals described in this paragraph are---

**(A)** women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

**(B)** infants under one year of age,

**(C)** children who have attained one year of age but have not attained 6 years of age, and

**(D)** children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) of this section and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

**(2)(A)(i)** For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the

percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after---

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than-

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes o[ paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17) of this section, for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV),

(a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section.-

**(A)** application of a resource standard shall be at the option of the State;

**(B)** any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI of this chapter:

**(C)** any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV of this chapter:

**(D)** the income standard to be applied is the appropriate income standard established under paragraph (2): and

**(E)** family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV of this chapter (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) of this section), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

**(4)(A)** In the case of any State which is providing medical assistance to its

residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) of this section and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) of this section in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

**(B)** In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) of this section and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

**(m) Description of individuals**

(1) Individuals described in this paragraph are individuals--

**(A)** who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) of this title),

**(B)** whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph 2(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (I)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) of this section and at the State's option, the State may use under paragraph (I)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A) of this section.

(C) The provisions of section 1396d(p)(2)(D) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1396d(p) of this title.

(3) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the

State plan by virtue of subsection (a)(10)(A)(ii)(X) of this section--

**(A)** the income standard to be applied is the income standard described in paragraph (I)(B). and

**(B)** except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section require or permit such treatment for other individuals.

**(4)** Notwithstanding subsection (a)(17) of this section, for qualified medicare beneficiaries described in section 1396d(p)(1) of this title---

**(A)** the income standard to be applied is the income standard described in section 1396d(p)(1)(B) of this title, and

**(B)** except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

**(n) Payment amounts**

In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary,the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of Payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

**(o) Certain benefits disregarded for purposes of determining post-eligibility contributions**

Notwithstanding any provision of subsection (a) of this section to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of sub-paragraph (E) or (G) of section 1382(e)(1) of this title to an individual who--

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid, will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital,

skilled nursing facility, or intermediate care facility.

**(p) Exclusion power of State; exclusion as prerequisite; for medical assistance payments; "exclude" defined**

(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under section 1320a-7, 1320a-7a, or 1395cc(b)(2) of this title.

(2) In order for a State to receive payments for medical assistance under section 1396b(a) of this title, with respect to payments the State makes to a health maintenance organization (as defined in section 1396b(m) of this tit[e) or to an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that--

(A) could be excluded under section 1320a.7(b)(8) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1320a-7(b)(8)(B) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a.7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

**(q) Minimum monthly personal needs allowance deduction; "institutionalized individual or couple" defined**

(1)(A) In order to meet the requirement of subsection (a)(50) of this section, the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance--

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple--

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this Paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

**(r) Disregarding payments for certain medical expenses by institutionalized individuals**

(1) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that

are not subject to payment by a third party, including--

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) of this section or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology--

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental under subchapter XVI of this chapter, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10) of this section, methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

**(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years**

In order to meet the requirements of subsection (a)(55) of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital

described in section 1396r of this title shall--

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

**(t) Authority of Secretary; limitations**

Except as provided in section 1396b(i) of this title, nothing in this subchapter (including sections 1396b(1) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.

**(u) Qualified COBRA continuation beneficiaries**

(1) Individuals described in this paragraph are individuals--

**(A)** who are entitled to elect COBRA continuation coverage (as defined in Paragraph (3)).

**(B)** whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved,

**(C)** whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

**(D)** with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this subchapter resulting

from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

**(2)** For purposes of subsection (a)(10)(F) of this section and this subsection, the term "COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

**(3)** In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C.A. §300bb-1 et seq.] section 4980B of Title 26, or title VI of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1161 et seq.]

**(4)** Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI) of this section--

**(A)** the income standard to be applied is the income standard described in paragraph (I)(B), and

**(B)** except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17) of this section, require or permit such treatment for other individuals.

**(v) State agency determination of disability and blindness and provision of medical assistance prior to final determination by Administration**

(1) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations,the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

**(w) Maintenance of written policies and procedures respecting advance directives**

(1) For purposes of subsection (a)(57) of this section and sections 1396b(m)(1)(A) and 1396n(c)(2)(E) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization--

(A) to provide written information to each such individual concerning--

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights:

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual--

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

**(x) Physician Identifier system; establishment**

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

**(y) Intermediate sanctions for psychiatric hospitals**

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1396d(h) of this title) and further finds that the hospital's deficiencies--

**(A)** immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

**(B)** do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter---

**(A)** within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

**(B)** within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under

section 1396b(a) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if--

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this Paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

# APPENDIX II

## DEPARTMENT OF HUMAN SERVICES MANUAL §1062.9-1063.211

## MEDICAL SERVICES FOR PERSONS UNDER 21 YEARS OF AGE

1063 Eligibility.

1063.1 Determination of Eligibility. Children who are categorically needy and receiving a money payment, children included in AFDC Foster Care, and children receiving a State Supplemental Payment (B or D), are pre-determined financially eligible for the Crippled Children's Program (CCP). Those children determined categorically needy under Title XIX and not receiving a money payment are also financially eligible for CCP.

For all other children, the worker reviews Forms PS-1 and MS-MA-CC-VR-MA-1 to verify financial eligibility for CCP. Financial eligibility is first determined using Title XIX income and resource standards. (see Section 1020). If the child is not Title XIX eligible, then CCP income and resource standards are applied. If the child is determined medically needy, using Title XIX income and resource standards, CCP income standards must then be used to determine eligibility for CCP services.

Documentation of income and resources and any other conditions which might effect the eligibility of this child to receive CCP services must be included in the case record.

A determination of medical eligibility for CCP must be made for all children.

1-63.2 Conditions of Eligibility.

1063.21 Financial Eligibility. A child is considered financially eligible for CCP if gross income does not exceed the CCP income standard (see Appendix-C-2-b).

1063.211 Consideration of Income for CCP Eligibility. All available income is considered in determining CCP eligibility. Available income is defined as all income "in hand" or under the control of the individual for the period of certification. If gross income exceeds the CCP income standard, the child is not income eligible for CCP. If gross income does not exceed the CCP income standard, the child is considered income eligible for CCP. Computation for determination of CCP income eligibility is made on Form MA-2.

Consideration of Resources for CCP Eligibility. Appendix C-2 is used to determine resource eligibility for CCP.

Eligibility for CCP is determined only after categorically and medically needy maximum reserves are exceeded. The same

procedures for determining resources are used for both Title XIX and CCP (see Section 1020).

Only liquid resources in hand during the month(s) of services are considered in determining CCP eligibility. Non-liquid resources are disregarded for CCP eligibility purposes.

Liquid resources are defined as those resources that can be readily converted to cash. The following are considered liquid resources:

Cash, savings accounts, checking accounts
Savings certificates (C.D.'s)
Stocks, bonds
Trust funds
Gifts, inheritances
Insurance settlements

If liquid resources exceed the resource standard, any amount above the standard must be considered as a "spenddown" and must be applied toward an incurred medical expense before certification can be made for CCP. The client is notified of the spenddown amount by Form CCP-1, Notice for CCP Spenddown, and is advised that spenddown must be applied within thirty (30) days of the date of the notice. The case is ineligible for any month

that liquid resources exceed the standard and client fails or refuses to apply the spenddown.

Okla. DHS Issued 11-1-86

# APPENDIX III

## TIMING, METHOD AND MANNER OF RAISING FEDERAL QUESTION

## TIMING, METHOD AND MANNER OF RAISING FEDERAL QUESTION

After the state district trial court issued its decision finding that DHS was estopped to find the trust assets as "available resources" DHS appealed the case to the Supreme Court. In DHS's Exhibit "C" to its Petition In Error, DHS asserted the following error:

> "The trial court erroneously found Ellen Barker's trust assets did not constitute a resource for purposes of eligibility for medical benefits."

In DHS's Brief In Chief to the Oklahoma Supreme Court, DHS raised the issue of Medicaid Qualifying Trusts arguing the MQT statute illustrated the intent of Congress to make discretionary trusts fully available. DHS also made this argument to demonstrate that the complexity of the program prohibited any DHS official from making a promise of continued eligibility as

had been argued by the Trust Company. In its Brief at pages 16 and 17, DHS stated:

> Under both approved plans, Medicaid and CCP, the certification period for benefits in 1981 was for six (6) months. This is a maximum period of time a person could be eligible before recertification. At each recertification, the resource issue is again examined by DHS. Additionally, in 1981, appendix C-2 was used in both Medicaid and CCP (then CCU) programs to establish a resource limit. In 1981, the resource limit for both programs was $1,500.00. The monies Ellen Barker received in 1981, $818,000.00, were clearly a resource which would have immediately made Ellen Barker ineligible for assistance. Using these fairly simple rules of eligibility for all clients, it is impossible for any employee of DHS to guarantee eligibility or make an agreement to waive the regulations.
>
> To further illustrate the impossibility of the agreement Herbert Hyde sought to make, the Court should consider the provisions of 42 U.S.C. §1396(a)(K). This provision, known as the Medicaid qualifying trust provision, was passed by

> Congress on April 7, 1986. This provision, although passed approximately five years after the alleged agreement, demonstrates the complexities of these government programs and how they change over time. Section (k) of 42 U.S.C. §1396a provides that if a trust is discretionary then the full amount of discretion is used against the beneficiary in determining eligibility. This statute applies to Medicaid eligibility when a trust is at issue whether or not the discretion is exercised. Thus, if it is possible in the trustee's discretion to pay one million dollars to the beneficiary, then this is assumed in accordance with the Medicaid Act in determining the client's eligibility.
>
> Because of the above cited regulations and the changes in the law, Herbert Hyde was powerless to make the type of agreement the Court suggests he made. DHS administered federal-state programs simply do not allow those with assets of close to one million dollars to be welfare eligible.

DHS's Brief In Chief before the Supreme Court of Oklahoma, Case No. 74,000, filed

February 14, 1990, pgs. 16-17 (footnote omitted).

After the case was assigned from the Oklahoma Supreme Court on October 26, 1990, pursuant to Rule 1.204(II) of the Rules for the Management of Workload in the Supreme Court, the Oklahoma Court of Appeals, Division III, issued a memorandum opinion on April 30, 1991. The decision reversed the ruling of the trial court finding DHS was not estopped to consider trust assets as resources. The Oklahoma Court of Appeals stated:

> An agreement by a DHS employee to accept two hundred thousand dollars ($200,000.00) for all past and future medical expenses of Ellen was ultra vires, or, outside the scope of his authority. We are unaware of any authority for such a contract, and none has been cited to us. The doctrine of estoppel has no application where a state employee's acts are beyond the scope of his employment. Ashland Oil, Inc. v. Corporation

Commission, 595 P.2d 423 (Okl. 1979); State ex rel., Commissioners of the Land Office v. Phillips Petroleum Co., 258 P.2d 1193 (Okl. 1953); State ex rel., Commissioners of the Land Office v. Lamascus, 263 P.2d 426 (Okl. 1953). Those dealing with public officials are charged with notice of the limitations of the officials' powers. Gamill v. Shackelford, 480 P.2d 920 (Okl. 1970).

Trust Company, as guardian of Ellen's estate, may not be heard to complain of detrimental reliance upon the State's acts, as Trust Company and its predecessors knew, or should have known, that the agreement entered into by a DHS employee purportedly waiving any future consideration of Ellen's settlement funds as an "available resource" was illegal and therefore ultra vires.

Evidence was introduced to show an estate for Ellen in excess of one million dollars ($1,000,000.00) at the time of denial of benefits. The funds used by DHS to pay Ellen's medical claims contemplate an indigent person. We find the trial court to have erred when it entered an order holding DHS to be estopped from asserting that

> the trust was an "available resource" to Ellen.

Trust Company of Oklahoma v. State of Oklahoma ex rel. DHS, Oklahoma Supreme Court Case No. 74,000, Decision of Oklahoma Court of Appeals p. 3 (April 13, 1991).

After the decision by the Oklahoma Court of Appeals, the Trust Company filed an application for certiorari with the Oklahoma Supreme Court on July 22, 1991. In the Petition for Certiorari, the Trust Company raised the estoppel issue and stated:

> "b. The memorandum opinion has decided a question of substance not heretofore determined by this Court. The Court of Appeals has in effect found that a discretionary trust for nonmedical purposes is an "available resource" which can be invaded by the beneficiary for payment of her medical expenses. Other jurisdictions have held that a discretionary trust is not an "available resource."

Thus, in its application for certiorari, the Trust Company raised the core issue of whether the trust constituted an available

resource. On September 17, 1991, the Supreme Court accepted certiorari stating:

> "This order is entered subject to the inherent right of this Court, in its discretion, to order the filing of additional briefs if deemed necessary by the Court."

No other briefs were filed by the parties.

On December 17, 1991, the Oklahoma Supreme Court squarely ruled upon the issues presented for review to this Court. First, the Oklahoma Supreme Court ruled DHS had waived any argument regarding the payment of income from the trust. The Court did so by footnote after framing the issue in the case:

> A single issue of first impression is presented -- whether a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is an available resource for medical assistance

> eligibility purposes. We find that a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not an "available resource" under 42 U.S.C. §1396a(a)(17)(B)(Supp. 1990) or a "liquid resource in hand" within the meaning of DHS Manual §1063.212(11/1/86) for medical eligibility purposes.
>
> 1. The Department of Human Services does not allege on certiorari that distributions paid to Barker's mother rendered the minor child ineligible for medical benefits. Failure to raise the issue in the petition for certiorari is fatal to its consideration. Bayly, Martin & Fay, Inc. v. Pickard, 780 P.2d 1168, 1170 (Okla. 1989).

Trust Company of Oklahoma v. State ex rel. DHS, 825 P.2d 1295, 1296-97 (OKla. 1991).

The Oklahoma Supreme Court also ruled that the Ellen Barker Trust was not a Medicaid Qualifying Trust. This issue was

ruled upon in footnote 31. The Court found that because the settlor was the Ganado School District (the tortfeasor) that the settlor was not the beneficiary. The Court stated:

> Two jurisdictions find that a trust fund is an available resource for medical eligibility purposes. Matter of Welfare of K.S., 427 N.W.2d 653, 659-60 (Minn. 1988); Arkansas Dept. of Human Services v. Donis, 280 Ark. 169, 655 S.W.2d 452, 454 (1983).
>
> Other cases in which courts have found that a trust is an available resource are distinguishable from the facts presented here. In 42 U.S.C. §1396a(k) (Supp. 1990), Congress has prohibited the creation of medicaid qualifying trusts for the purpose of meeting medical eligibility requirements. Section 1396a(k) defines a medicaid qualifying trust as a non-testamentary trust created by an individual or the individual's spouse under which the individual is the beneficiary of all or part of the trust payments. Here, the settlor is not the beneficiary, Barker, but the tortfeasor, Ganado School District.

Trust Company of Oklahoma, supra 825 P.2d at 1302 (Okla. 1991).

Finally, the Court ruled upon the core issue of whether the trust was a resource. The Court found that it agreed with the reasoning of the majority of jurisdictions stating:

> The courts holdings that a trust is not an available resource give effect to the settlor's intent, expressed through the trust instrument. They recognize that a settlor may want to supplement rather than to supplant public financial assistance. They reason that settlors attempting to provide for a handicapped person should not be required to either bankrupt estates or leave the disadvantaged party to the vagaries of public assistance programs. Additionally, these courts have not been willing to find that trust assets are available resources for medical assistance purposes when to do so would authorize a rapid and total dissipation of a trust estate intended to provide only supplementary benefits.

Because, absent a conflict with a principle of law, interpretation of a trust's terms are controlled by the settlor's intent, we find the reasoning of the majority persuasive. Here, the trust instrument provides that its primary purpose is to furnish Barker with "**nonmedical equipment, care, education, training, rehabilitation, entertainment, transportation, or assistance needed to assure her of as natural and pleasant a life as is possible in her condition.**" The trustee is authorized to provide for medical expenses only if Barker ceases to qualify for public assistance. Trust instruments are generally construed in favor of their beneficiaries. If declarations of trust are clear and susceptible of only one meaning, the provisions of the trust govern its construction.

The trust instrument clearly indicates that its primary purpose is for nonmedical support. The trust was formed to provide those supplementary benefits not provided by public assistance. Requiring use of the trust assets until the income is depleted and the principal is reduced to $1,800.00 benefits the State, not Barker, and would nullify the settlor's intent. We

> find that a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not an "available resource" under 42 U.S.C. §1396a(a)(17)(B) (Supp. 1990) or a "liquid resource in hand" within the meaning of DHS Manual §1063.212 (11/1/86) for medical assistance eligibility purposes.

Trust Company of Oklahoma v. State ex rel. DHS, 825 P.2d at 1303-1304 (Okla. 1991) (citations omitted).

DHS then filed a Petition for Rehearing with the Oklahoma Supreme Court which raised a supremacy clause argument stating:

> Under the Supremacy Clause State Law Must Yield To The Intent of the Medicaid Act
>
> . . .
>
> DHS requests this Court to reconsider its opinion because implicit in the Court's ruling is the fundamental proposition that a private person, through a trust, can shelter resources by simply stating that as their intent. While this is

permissible in solely private transactions, DHS asserts that when applying the purpose of the Medicaid Act against the state law on trusts, the federal law must prevail.

. . .

Using the plain wording of the statute, and its congressional intent, the state law must do major damage to clear and substantial federal interests. The federal share of the Medicaid program has risen from roughly 60% to 70% (of every dollar spent) in the last five years in Oklahoma. Congress's intent was to prevent those who are affluent from using trusts to qualify for assistance because of the scarce monetary resources of states to fund the Medicaid program. This Court's holding that in state law the settlor's intent governs even when the intent is clearly (sic) shelter monies, which would be considered available resources, does substantial harm to the federal interest. The message sent by this holding is that if a settlor intends that resources are unavailable, they simply can make them unavailable. This is the result of allowing state law to control the definition of "available resources."

APP. 3

DHS' Petition for Rehearing And Brief In Support of Petition for Rehearing, pgs. 7, 8 and 10 (filed January 27, 1992).

Finally, in its Petition for Rehearing, DHS requested the Court reconsider its decision regarding whether the trust was a Medicaid Qualifying Trust. DHS stated in its brief:

> Based upon this ruling, (Barham v. Rubin, 816 P.2d 965 (Haw. 1991)), DHS respectfully requests that this Court grant rehearing to reconsider its decision whether the trust at issue is an MQT and therefore the assets are available resources. The record reflects that in this case all of the assets of the trust do go to the beneficiaries of Ellen Barker. Also, despite the fact that the grantor is not Ellen Barker, in every personal injury settlement or award, this device attempts to shield the very real fact that these monies were Ellen Barker's and through the trust are Ellen Barker's. Ellen Barker and her mother were the named plaintiffs in the personal injury action and should be considered to be in constructive receipt of the funds awarded. Ellen Barker, through

> her mother acting as her guardian, should be considered the "de facto" grantor for purposes of determining whether this trust is a (sic) MQT. To construe this trust otherwise permits Medicaid applicants to manipulate the federal law, shelter otherwise available resources and force the taxpayers of this country to pay for their medical care while other needy applicants must be turned away.

DHS' Petition for Rehearing and Brief In Support of Petition for Rehearing, page 8 (filed January 27, 1992) (citation added).

The Petition for Rehearing was denied by the Oklahoma Supreme Court on March 4, 1992.

# APPENDIX IV

## OPINION
## CERTIORARI TO THE COURT
## OF APPEALS, DIVISION III

## STATE OF OKLAHOMA

**IN THE SUPREME COURT**
**OF THE STATE OF OKLAHOMA**

OFFICIAL PUBLICATION

| | | |
|---|---|---|
| TRUST COMPANY OF OKLAHOMA, Guardian of the Estate of ELLEN LEA BARKER, a minor child, | ) | |
| Appellee, | ) | |
| v. | ) | No. 74,000 |
| STATE OF OKLAHOMA, ex rel. DEPARTMENT OF HUMAN SERVICES, | ) | |
| Appellant. | ) | |

**CERTIORARI TO THE COURT OF APPEALS, DIVISION III**

**Honorable Charles H. Headrick, Trial Judge**

The appellant, Oklahoma Department of Human Services (Department of Human Services), denied medical benefits based on the existence of a trust overseen by the appellee, Trust Company of Oklahoma (Trust Company/trustee). The trial court ruled in favor of the Trust Company. Although the Court of Appeals recognized that a settlement agreement entered by the Parties was meant to require payment of medical expenses by the Department of Human Services and to exclude the trust as an available resource, it reversed the trial court. It found that because the Department of Human Services' counsel was without authority to agree to the settlement agreement, it could

not be estopped by its agent's actions. We find that a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not an "available resource" under 42 U.S.C. §1396a(17)(B) (Supp. 199()) or a "liquid resource in hand" within the meaning of DHS Manual §1063.212 (11/1/86) for medical assistance eligibility purposes. The medical assistance case is reinstated from the date of termination subject to recertification as provided by the applicable program regulations.

**CERTIORARI PREVIOUSLY GRANTED; OPINION OF THE COURT OF APPEALS VACATED: TRIAL COURT AFFIRMED.**

Charles Lee Waters — For Appellant,
General Counsel
Howard J. Pallotta
Assistant General Counsel
Department of Human Services
Oklahoma City, Oklahoma

Roland Tague — For Appellee.
Groves & Tague
Oklahoma City, Oklahoma

**KAUGER, J.**

A single issue of first impression is presented[1] -- whether a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs,[2] is an

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[1]The Department of Human Services does not allege on certiorari that distributions paid to Barker's mother rendered the minor child ineligible for medical benefits. Failure to raise the issue in the petition for certiorari is fatal to its consideration. Bayly, Martin & Fay, Inc. v. Pickard, 780 P.2d 1168, 1170 (Okla. 1989).

[2]The trust agreement provides in pertinent part:

> ". . . A. Purposes: Grantor is creating this trust, and will transfer certain assets to the trust for the primary benefit of a five year old girl named Ellen Barker ('Ellen'), who was severely injured in an automobile accident in which an employee of grantor was allegedly at fault. As a result of the accident, Ellen's spinal cord was damaged, leaving her permanently paralyzed

available resource for medical assistance

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> from the neck down and unable to breath (sic) without the assistance of a respirator. Ellen has been hospitalized since the accident and will continue to be hospitalized or institutionalized in Oklahoma City for an indefinite period of time. Ellen (sic) medical needs have been provided for by the Oklahoma Department of Human Services; however, in addition to her medical needs, Ellen will need special care throughout her lifetime, in order for her to live as normal and productive a life as possible under these circumstances. The primary purpose of this trust, therefore, is to furnish Ellen, during her lifetime, with the nonmedical equipment, care, education, training, rehabilitation, entertainment, transportation, or assistance which she will need to assure her of as natural and pleasant a life as is possible in her condition. If, for any reason, Ellen ceases to qualify for medical assistance, then the trustee may in its discretion, also provide any medical assistance which Ellen may require. . . ."

eligibility purposes.[3] We find that a

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[3]From 1981 to March, 1986, Barker received medicaid benefits through Title XIX--Grants to States for Medical Assistance Programs, 42 U.S.C. §1396 et seq. (1984). Medical benefits were provided through the Oklahoma Crippled Children's Act (Crippled Children's Act/Program), 10 O.S. 1981 §175.1, et seq. From March 1986 until June 30, 1987. Under both programs, an applicant may hold a maximum of $1,800.00 in available resources to qualify for medical services. DHS Manual §1022.22 (Reissued 11/1/86) provides in pertinent part:

> "Maximum Capital Resources . . . Appendix C-2 shows the maximum capital resources for the medically needy and is used in determining eligibility for Title XIX. . . ."

DHS Manual §1063.212 (11/1/86) provides in pertinent part:

> "Consideration of Resources for CCP Eligibility Appendix C-2 is used to determine resource eligibility for CCP. Eligibility for CCP is determined only after categorically and medically needy maximum reserves are exceeded. The same procedures for determining resources are used for both Title XIX and CCP (see Section 1020).

trust, created for the primary purpose of

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> Only <u>liquid</u> resources in hand during the month(s) of services are considered in determining CCP eligibility. <u>Non-liquid</u> resources are disregarded for CCP eligibility purposes.
>
> <u>Liquid sources</u> are defined as those resources that can be readily converted to cash. The following are considered liquid resources:
>
> Cash, savings accounts,
> checking accounts
> Savings certificates (C.D.'s)
> Stocks, bonds
> Trust funds
> Gifts, inheritances
> Insurance settlements . . ."

Medical Assistance Standards - Medically Needy - Appendix C-2 provides in pertinent part:

> ".. . II. <u>Capital Resources</u> Maximum allowable in available capital resources according to family size:
>
> <u>Size of Family</u>
>
> | | |
> |---|---|
> | 1 person (either adult or child) | $1800.00 cash resources or equivalent ..." |

providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not an "available resource" under 42 U.S.C. §1396a(17)(B) (Supp. 1990)[4] or a "liquid resource in hand" within the meaning of DHS Manual §1063.212 (11/1/86)[5] for medical eligibility

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[4]Title 42 U..S.C. §1396a (Supp. 1990) provides in pertinent part:

"(a) Contents

A state plan for medical assistance must--

> . . . (17) . . . (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . ."

[5]DHS Manual §1063/212 (11/1/86), see note 3, supra.

purposes. The medical assistance case is reinstated from the date of termination subject to recertification as provided by the applicable program regulations.

**FACTS**

Ellen Lea Barker (Barker/ beneficiary/ minor child), is an Oklahoma resident. On September 20, 1980, she and her family were visiting in Arizona when their car was struck by a bus operated by the Ganado Public School District No. 19 (Ganado School District/settlor). Barker's injuries caused permanent paralysis from the neck down. In 1981, the minor child was transferred to Oklahoma Children's Memorial Hospital where she remained until June, 1986. Upon her dismissal, she moved home. Barker continues to use a ventilator, and she requires nursing assistance and other specialized medical equipment.

Barker's mother filed suit against the Ganado School District in Arizona (Arizona suit/action) on the minor child's behalf. During the first six months that Barker was hospitalized in Oklahoma, she incurred approximately $160,000 in medical expenses. In an effort to obtain reimbursement, the appellant, Oklahoma Department of Human Services (Department of Human Services), filed a lien against any proceeds which might be collected in the Arizona suit.[6]

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[6]Title 56 O.S. 1981 §200 provides in pertinent part:

> "(a) Whenever the Department of Human Services pays medical expenses for or on behalf of a person who has been injured, or who has suffered a disease, as a result of the negligence or act of another person, the Department shall, if such injured or diseased person asserts or maintains a claim against such other person or tort feasor for damages on account of such injury or disease, have a lien to the

On May 18, 1981, the Arizona court entered an order approving the settlement of Barker's claim. Pursuant to the settlement, $818,940.00 were paid to the appellee, Trust Company of Oklahoma (Trust Company/ trustee)[7] to be held pursuant to a trust

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> extent of the amount so paid upon that part going or belonging to such injured or diseased person of any recovery or sum had or collected or to be collected by such injured or diseased person, or by his heirs, personal representative or next of kin in case of his death, whether by judgment or by settlement or compromise . . ."

Section 200 was amended in 1986. The quoted portion of §200 now appears in subsections (A) and (D) of the revised statute. However, the language remains substantially similar to that found in the 1981 version.

[7]Title 12 O.S. 1981 §83 provides in pertinent Part:

> "Monies recovered in any court proceeding by a next friend or guardian ad litem for or on behalf of a person who is less than eighteen (18) years of age

agreement reviewed and approved by the Arizona court. On May 22, 1981, the Trust Company filed an application to approve inventory, disbursement and the trust agreement in Oklahoma County. The application provided that: 1) the trustee

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> in excess of One Thousand Dollars ($1,000.00) over sums sufficient for paying costs and expenses including medical bills and attorney's fees shall, by order of the court, be deposited in a banking or savings and loan institution approved by the court. Until the person becomes eighteen (18) years of age, withdrawals of monies from such account or accounts shall be solely pursuant to order of the court made in the case in which recovery was had. When an application for the order is made by a person who is not represented by an attorney-at-law, the judge of the court shall prepare the order."

Section 83 was amended in 1984 to allow the use of annuities and structured settlements. The language of the 1981 version of §83 remains intact in the revised statute.

had received $818,940.00 to be held for Barker: and 2) the settlement was subject to a lien in favor of the Department of Human Services. The Trust Company requested an order allowing disbursement of $200,000.00 to the Department of Human Services in return for a full and complete disclaimer of any further or future interest in the trust estate. On the same date, the district court entered an order signed by the Department of Human Services' counsel approving the inventory of the trust and the trust agreement. The order also approved the disbursement to the Department of Human Services "in full and complete satisfaction and accord as to any lienable interest held

by said Department in the funds arising from the litigation in Arizona."[8]

From 1981 to March, 1986, Barker received medicaid benefits through Title XIX--Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. §1396 (1984)

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[8]Because the Barker trust fund is not an available resource for medical eligibility purposes, we need not determine whether the facts and circumstances--Department of Human Services' participation in the settlement process--implicate a prevailing public interest which will except it from the general rule precluding the use of estoppel against the government. Spencer Dev. Co. v. Independent School Dist. No. I-89, 741 P.2d 477, 481 (Okla. 1987); Burdick v. Independent School Dist. No. 52, 702 P.2d 48, 53 (Okla. 1985). Noting that the doctrine of estoppel against the government has been decisively eroded in recent years, a federal district court found that estoppel would apply against the government in a situation in which an applicant for benefits was given wrong information for the purpose of filing an application. Coty v. Harris, 495 F.Supp. 452, 454 (W.D.Va. 1980). See also, Annot., "Modern Status of Applicability of Doctrine of Estoppel Against Federal Government & Its Agencies," 27 A.L.R.Fed. 702, 719-722 (1976).

et seq. Medical benefits were provided through the Oklahoma Crippled Children's Act (Crippled Children's Act/Program), 10 O.S. 1981 §175.1, et seq. from March 1986 until June 30, 1987. Under both programs, an applicant may hold a maximum of $1,800.00 in available resources to qualify for medical services.[9] When Barker's mother filed a re-application for benefits on March 14, 1985, she reported the existence of the trust. Medical coverage was switched from Title XIX to the Crippled Children's Program because of a belief that the trust made Barker ineligible for Medicaid. In 1985, the trust contained approximately $1,000,000.00. By June 30, 1987, the trust

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[9]DHS Manual §1022.22 (Reissued 11/1/86), see note 3, supra; DHS Manual §1063.212 (11/1/86), see note 3, supra; Medical Assistance Standards - Medically Needy - Appendix C-2, see note 3, supra.

corpus consisted of approximately 1.2 million dollars.

On May 29, 1987, the Department of Human Services notified the Trust Company that Barker's medical assistance benefits would be terminated effective June 30.[10] The basis for termination was a determination that the trust fund constituted an available resource for purposes of the Crippled Children's Act.[11] The Trust Company requested an administrative hearing before the Appeals Unit to review the denial of benefits on June 29, 1987. A hearing was conducted before an administrative law judge on

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[10]Some of Barker's expenses were paid from the Crippled Children's Program from August 28, 1986 to January 1, 1987 pursuant to an agreement between the Trust Company and Human Services.

[11]DHS Manual §1063.212 (11/1/86), see note 3, supra.

September 10, 1987. On February 12, 1988, the administrative law judge sustained the Department of Human Services' termination of benefits.[12]

The Trust Company received the decision of the appeals unit on February 19 and filed a petition with the district court on March 14 pursuant to 56 O.S. Supp. 1985 §168(D).[13] After hearing argument and

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[12]The delay in the issuance of a decision was predicated on a request by the Trust Company for the Department of Human Services' records concerning the 1981 settlement negotiations. No record of these negotiations was ever located by the Department of Human Services.

[13]Title 56 O.S. Supp. 1985 §168(D) provides:

> "Any Person aggrieved by any final decision of the Department may petition the district court in which the recipient resides for a judicial review of the decision pursuant to the provisions of Sections 318 through 323 of Title 75 of the Oklahoma Statutes. A copy of the

considering the parties' brief, the trial court ruled from the bench in the Trust Company's favor.[14] The trial court found that the decision of the Appeals Unit was clearly erroneous in light of the evidence on estoppel and ordered the reinstatement of medical benefits. The Department of Human Services appealed pursuant to 75 O.S. 1981 §323.[15] Although the Court of Appeals

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> petition shall be served by mail upon the General Counsel of the Department."

[14]The trial court's decision is also found in the journal entry of judgment dated August 22, 1989, and filed on October 5, 1989.

[15]Title 75 O.S. 1981 §323 provides:

> "An aggrieved party, or the agency, without any motion for a new trial, may secure a review of any final judgment of a district or superior court under this act by appeal to the Supreme Court. Such appeal shall be taken in the manner and time provided by law for appeal to the Supreme Court

recognized that the 1981 settlement agreement was meant to require payment of medical expenses by the Department of Human Services and to exclude the trust as an available resource, it reversed the trial court. The Court of Appeals found that because the Department of Human Services' counsel was without authority to enter the settlement agreement, it could not be estopped by its agent's actions. On September 17, 1991, we granted certiorari to address a question of first impression in Oklahoma--whether a trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify

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from the district court in civil actions. An agency taking an appeal shall not be required to give bond."

for medical assistance programs, is an available resource for medical eligibility purposes.

**A TRUST, CREATED FOR THE PRIMARY PURPOSE OF PROVIDING NONMEDICAL SUPPORT AND CONTAINING A PROVISION ALLOWING THE TRUSTEE DISCRETION TO PROVIDE MEDICAL CARE IF THE BENEFICIARY CEASES TO QUALIFY FOR MEDICAL ASSISTANCE PROGRAMS, IS NOT AN "AVAILABLE RESOURCE" UNDER 42 U.S.C. §1396A(17)(B) (Supp. 1990) or "LIQUID RESOURCE IN HAND" WITHIN THE MEANING OF DHS MANUAL §1063.212 (11/1/86) FOR MEDICAL ELIGIBILITY PURPOSES.**

The Trust Company asserts that the trust is not an available resource for medical assistance eligibility purposes. The Department of Human Services characterizes this issue as "interesting" but argues that a finding that it is not bound by estoppel moots the question. Without deciding the estoppel issue, we disagree. If the Department of Human

Services was not estopped by the actions of its agent in the settlement proceedings,[16] Barker may still qualify for assistance if she meets the resource requirements under either Medicaid or the Crippled Childrens' Act.

Medicaid was enacted in 1965 as a cooperative federal-state endeavor designed to provide health care to needy individuals.[17] States are not required to

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[16]See, Spencer Dev. Co. v. Independent School Dist. No. I-89, see note 8, supra; Burdick v. Independent School Dist. No. 52, see note 8. See also, Coty v. Harris, note 8, supra; Annot., "Modern Status of Applicability of Doctrine of Estoppel Against Federal Government & Its Agencies," note 8, supra and accompanying discussion.

[17]Atkins v. Rivera, 477 U.S. 154, 156, 106 S.Ct. 2456, 2458, 91 L.Ed.2d 131, 137 (1986); Schweiker v. Gray Panthers, 453 U.S. 34, 36, 101 S.Ct. 2633, 2636, 69 L.Ed.2d 460, 465 (1981); Title 42 U..S.C. §1396 (Supp. 1990) provides:

> "For the purpose of enabling each State, as far as practicable

participate in the program. However, once a state chooses to adopt the program, it must create a plan conforming with the requirements of the federal statute, 42 U.S.C. §1396 et seq., and related federal

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under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independent or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance."

regulations.[18] Participating states must provide medicaid coverage to the categorically needy.[19] The categorically

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[18]Schweiker v. Gray Panthers, see note 17 at 2637, supra; Washington v Bowen, 815 F.2d 549, 552 (9th Cir.1987); 42 U.S.C. §1396 (Supp.1990), see note 17, supra; E. Brantley, "Use of the Trust to Manage Property of the Elderly or Disabled,'' 42 Ark. L.Rev. 568, 619 (1989).

[19]Atkins v. Rivera, see note 17, supra; Title 42 U.S.C. §1396a(a)(10)(A)(i) (Supp. 1990) provides in pertinent part:

(a) Contents

". . . A state plan for medical assistance must--

(10) provide--

(A) for marking medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to--

"(i) all individuals--

. . . (II) with respect to whom supplemental security income benefits are being paid

needy are those persons eligible for cash assistance under either of two programs: Supplemental Security Income for the Aged, Blind, and Disabled (SSI), 42 U.S.C. §1381 et seq. or Aid to Families with Dependent Children (AFDC), 42 U.S.C. §601 et seq. Because she receives SSI benefits, Barker is classified as categorically needy.[20]

The Medicaid Act requires the states to base assessments of financial need only on

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under subchapter XVI of this chapter or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title). . . ."

[20]States may also provide assistance to the medically needy. The medically needy become eligible for medicaid benefits when their income and assets are reduced by incurred medical expenses that reduce their income and assets below certain established levels. Ramsey v. Department of Human Services, 301 Ark. 285, 783 S.W.2d 361-62 (1990).

resources available to the applicant or recipient. The Secretary of Health and Human Services (Secretary) is authorized to promulgate rules to determine whether resources are available within the meaning of 42 U.S.C. §1396a(17)(B) (Supp. 1990).[21] Because Medicaid eligibility is determined using the same methodology for the treatment of resources as is applicable to the SSI program,[22] SSI regulations are

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[21] Schweiker v. Gray Panthers, see note 17 at 37, supra; Clark v. Comm'r, 200 Conn. 390, 551 A.2d 729, 733 (1988); Title 42 U.S.C. §1396a(17)(B) (Supp.1990), see note 4, supra.

[22] 42 C.F.R. §435.700 (1990) provides in pertinent part:

> "This subpart prescribes financial requirements for determining the eligibility of categorically needy individuals under Subparts B and C of this Part. The requirements apply only to individuals who are not receiving AFDC, Ssi, or an optional State supplement. The

instructive. Federal regulations defining resources for SSI provide that a resource may be cash, liquid assets, or other property rights. Trust funds are not listed as available resources. If a property right cannot be liquidated, it is not considered a resource.[23]

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> financial eligibility requirements of AFDC, Ssi, or the State supplement apply to individuals receiving those payments. . . ."

Miller v. Ibarra, 746 F.Supp 19, 26 (D.Colo. 1990); Lang v. Commonwealth, 515 Pa. 428, 528 A.2d 1335, 1339 (1987).

[23]20 C.F.R. §416.120(a)(3) (1990) provides:

> "**Resources** means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance (see §416.1201(a))."

42 C.F.R. §416.1201(a)(1) (1990) provides:

In order to implement binding federal guidelines governing Medicaid,[24] the Department of Human Services promulgated DHS manual §1000 (11/1/86).[25] Section 1000

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> "**Resources: defined.** For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.
>
> (1) If the individual has the right, authority or power to liquidate the Property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)."

[24] Schweiker v. Gray Panthers, see note 17 at 37, supra; Washington v Bowen, see note 18, supra; 42 U.S.C. §1396 (Supp. 1990), see note 17, supra; E. Brantley,"Use of the Trust to Manage Property of the Elderly or Disabled," see note 18, supra.

[25] DHS Manual §1000 (11/1/86) Provides in pertinent part:

requires the Department of Human Services to make payments within the scope of Medicaid or the Crippled Children's Act. The standards for medical care and services are the same under both programs. DHS Manual §1022.23 (11/1/86) defines available resources for purposes of Medicaid as those which are "in hand" or under the control of the individual for the period of

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"The Department of Human Services (DHS) provides payment for medical services, within the scope of the Medicaid Program (which is also known as Medical Assistance and as Title XIX) or the Crippled Children's Program for persons under 21 years of age who meet the respective eligibility requirements for these programs. . . . The standards are the same for medical care and medical services provided or paid for by the Department, whether payment is made through the Crippled Children's Program or the Title XIX Program. . . ."

certification.[26] Pursuant to DHS Manual §1063.212 (11/1/86), the same procedures are used for determining resources under both Medicaid and the Crippled Children's Program. Section 1063.212 provides that only liquid resources in hand during the month of services are considered in determining eligibility for the Crippled Children's Program. Trust funds are included within the definition of liquid resources for purposes of the Crippled Children's Program.[27] However, because federal law governs the availability of

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[26]DHS Manual §1022.23 (11/1/86) provides in pertinent part:

> "Determination of Eligibility for Title XIX Payments. Available income and resources are those which are "in hand" or under the control of the individual for the period of certification. . . ."

[27]DHS Manual §1063.212 (11/1/86), see note 3, supra.

resources for purposes of Medicaid[28] and because under the DHS guidelines the same standards of availability apply for purposes of Medicaid and the Crippled Children's program,[29] a determination of the availability of the instant trust under federal guidelines governs Barker's eligibility for medical assistance--**available resources in hand and liquid resources in hand must be assigned a definition consistent with that of available resources under the federal act.**

Relying upon pertinent federal and state statutes and regulations, the minority

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[28]Schweiker v. Gray Panthers, see note 17 at 2637, supra; Washington v Bowen, see note 18, supra; 42 U.S.C. §1396 (Supp. 1990), see note 17, supra; E. Brantley, "Use of the Trust to Manage Property of the Elderly or Disabled," see note 18, supra.

[29]DHS Manual §1063.212 (11/1/86), see note 3, supra.

of jurisdictions which have considered the issue of the availability of a trust fund for medical eligibility purposes have found that the trusts are not available resources for the determination of a beneficiary's eligibility for medical assistance.[30]

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[30]Eight jurisdictions find that a trust is not an available resource for medical eligibility purposes. Miller v. Ibarra, see note 22 at 27, supra (Applying Colorado law and federal statute.); Lang v. Commonwealth, see note 22 at 1345, supra [Prior to the Pennsylvania Supreme Court's determination in Lang, a lower court had held that trusts were available resources for medical eligibility purposes. Stoudt v. Commonwealth, 76 Pa.Commw. 576, 464 A.2d 665-66 (1983). Since the decision in Lang, the Commonwealth courts have split on the issue of availability. Commonwealth Bank & Trust Co. v. Commonwealth, 128 Pa.Commw. 528, 563 A.2d 1299, 1301 (1983) (Indicating that the decision in Lang applied only to recipients of funds under the Mental Health & Mental Retardation Act of 1966.); Snyder v. Commonwealth, ___ Pa.Commw. ___, 556 A.2d 31, 33 (1989) (Noting that the Pennsylvania Supreme Court's decision that the trust in Lang was not an available resource for medical eligibility purposes was independent of its determination that the trust had no legal duty to provide support to the

beneficiary.]; Zeoli v. Comm'r of Social Ser., 179 Conn. 83, 425 A.2d 553, 559, 21 A.L.R.4th 718, 727-28 (1979); Jansen v. Department of Public Welfare, 201 Neb. 185, 266 N.W.2d 742, 745 (1978); Kline v. Utah Dept. of Heath, 776 P.2d 57, 63 (Utah Ct.APP. 1989); Lineback v. Stout, 79 N.C. App. 292, 339 S.E.2d 103, 108 (1986); Tidrow v. Director, 688 S.W.2d 9, 13 (Mo.Ct.App. 1985); Hoelzer v. Blum, 93 A.D.2d 605, 462 N.Y.S.2d 684, 690 (1983). See, Annot., "Eligibility for Welfare Benefits as Affected by Claimant's Status as Trust Beneficiary," 21 A.L.R.4th 729, 734-740 (1983).

On appeal, the Department of Human Services attempted to distinguish some of these rulings on the basis that they referred to medically needy recipients rather than to those included within the categorically needy definition. This distinction is not persuasive. The methodology employed to determine eligibility for services is the same for both groups. Hogan v. Hecker, 769 F.2d 886, 888 (1985); Hession v. Illinois Dept. of Public Aid, 129 Ill.2d 535, 136 Ill.Dec. 65, 544 N.E.2d 751, 754 (1989); 42 U.S.C. §1396a(10)(C)(i) provides in pertinent part:

> ". . . (T)hat if medical assistance is included for any group of individuals described in section 1396(a) of this title who are not described in subparagraph

Courts in the minority[31] find that trust

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(A) or (E), then--

> (i) the plan must include a description of ... the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility shall be no more restrictive than the methodology which would be employed under the supplemental security Program . . . and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan . . ."

[31]Two jurisdictions find that a trust fund is an available resource for medical eligibility purposes. Matter of Welfare of K. S., 427 N.W.2d 653, 659-60 (Minn. 1988); Arkansas Dept. v. Donis, 280 Ark. 169, 655 S.W.2d 452, 454 (1983).

Other cases in which courts have found that a trust is an available resource are distinguishable from the facts presented here. In 42 U.S.C. §1396a(k) (Supp. 1990),

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Congress has prohibited the creation of medicaid qualifying trusts for the purpose of meeting medical eligibility requirements. Section 1396a(k) defines a medicaid qualifying trust as a non-testamentary trust created by an individual or the individual's spouse under which the individual is the beneficiary of all or part of the trust payments. Here, the settlor is not the beneficiary, Barker, but the tortfeasor, Ganado School District. 42 U.S.C. §1396a(k) provides in pertinent part:

> **"Treatment of potential payments from Medicaid qualifying trusts**
>
> (1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17) of this section, is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph

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(2).

(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual. . . .

(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship."

Hall v. Malstrom. 29 Wash.2d 746, 189 P.2d 471, 473 (1948); Couch v. Director, 795 S.W.2d 91, 94 (Mo.Ct.App. 1990); Hatcher v. Department of Health & Human Rehabilitative Serv., 545 So.2d 400, 402 (Fla.Dist.Ct.App. 1989); Cantor v. Department of Income Maintenance, 12 Conn.App. 435, 606 A.2d 606-

assets are available resources. These courts have refused to interpret a settlor's intent to be that he/she wanted public support to be used as a vehicle for preserving trust assets.[32]

The courts holding that a trust is not an available resource give effect to the settlor's intent, expressed through the trust instrument. They recognize that a settlor may want to supplement rather than to supplant public financial assistance.[33]

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07 (1987); Harrington v. Blum, 117 Misc.2d 623, 458 N.Y.S.2d 864, 866 (1982).

[32]McNiff v. Olmstead, 287 Minn. 40, 176 N.W.2d 888, 891 (1970).

[33]Miller v. Ibarra, see note 22 at 27, supra; Lang v. Commonwealth, see note 22 at 1345, supra; Zoeli v. Commissioner of Social Serv., see note 30 at 556, supra; Lineback v. Stout, see note 30 at 108, supra; Tidrow v. Director, see note 30 at 14; Hoelzer v. Blum, see note 30 at 690, supra. See also, W. McGovern, Jr., Wills, Trusts & Estates--Including Taxation & Future Interests, ch. 8, p. 309 (West 1988); 2 Scott, The Law of

They reason that settlors attempting to provide for a handicapped person should not be required to either bankrupt estates or leave the disadvantaged party to the vagaries of public assistance programs.[34] Additionally, these courts have not been willing to find that trust assets are available resources for medical assistance purposes when to do so would authorize a rapid and total dissipation of a trust estate intended to provide only supplementary benefits.[35]

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Trusts, §128.4, p. 354-55 (Little, Brown, & Co. 1987); C. Mooney, "An Estate Plan to Supplement Public Assistance for Disabled Persons," 25 Ariz. L.Rev. 939, 967 (1983).

[34]Lang v. Commonwealth, see note 22 at 1345, supra.

[35]Tidrow v. Director, see note 30 at 14, supra. A finding that the trust is liable for Barker's medical expenses would result in the trust being rapidly depleted. From September 1986 to September 1987, the trust expended $120,000.00 for Barker's

Because, absent a conflict with a principle of law, interpretation of a trust's terms are controlled by the settlor's intent,[36] we find the reasoning of the minority persuasive. Here, the trust instrument provides that its primary purpose is to furnish Barker with "**nonmedical equipment, care, education, training, rehabilitation, entertainment, transportation, or assistance needed to assure her of as natural and pleasant a life as is possible in her condition.**" The trustee is authorized to provide for medical

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medical expenses. If these expenses continue to be paid from trust assets, the trust will be depleted by the time Barker is twenty-one years old.

[36]In re Will of Dimick, 531 P.2d 1027, 1030 (Okla. 1975); Hurst v. Kravis, 333 P.2d 314, 318 (Okla. 1958); Annot., "Propriety of Considering Beneficiary's Other Means Under Trust Provision Authorizing Invasion of Principal for Beneficiary's Support," 41 A.L.R.3d 255, 260 (1972).

expenses only if Barker ceases to qualify for public assistance.[37] Trust instruments are generally construed in favor of their beneficiaries.[38] If declarations of trust are clear and susceptible of only one meaning, the provisions of the trust govern its construction.[39]

The trust instrument clearly indicates that its primary purpose is for nonmedical support. The trust was formed to provide those supplementary benefits not provided by public assistance. Requiring use of the trust assets until the income is depleted

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[37]See pertinent trust provision note 2, supra.

[38]Matter of Home-Stake Prod. Co. Deferred Compensation Trust, 598 P.2d 1193, 1196 (Okla. 1979); Harris Trust & Savings Bank v. Burlingame, 200 Okla. 29, 190 P.2d 1017, 1019 (1948).

[39]Matter of Home-Stake Prod. Co. Deferred Compensation Trust, see note 38, supra.

and the principal is reduced to $1,800.00[40] benefits the State, not Barker, and would nullify the settlor's intent. We find that a trust, created for the primary purpose of providing nonmedical support and containing a Provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not is not an "available resource" under 42 U.S.C. §1396a(17)(B) (Supp. 1990)[41] or a "liquid resource in hand" within the meaning of DHS Manual §1063.212 (11/1/86)[42] for medical assistance eligibility purposes.

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[40]Medical Assistance Standards - Medically Needy - Appendix C-2, see note 3, supra.

[41]Title 42 U.S.C. §1396a(17)(B) (Supp. 1990), see note 4, supra.

[42]DHS Manual §1063.212 (11/1/86), see note 5, supra.

## CONCLUSION

Economic reality demonstrates that the source of funds for public assistance programs is finite.[43] However, the principle of availability has served to prevent the States from attributing tangential sources of income or resources to an applicant for assistance.[44] The legislative history of §1396a(17)(B) indicates that the term "available" should be read as a limiting term. **Only those assets actually available to the applicant may be considered.** States may not over evaluate available resources.[45] Here, the

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[43]Coppola v. Fulton, 809 P.2d 1291, 1297 (Okla. 1991).

[44]Clark v. Commissioner of Income Maintenance 209 Conn. 390, 551 A.2d 729, 736 (1988).

[45]State v. Bowen, 815 F.2d 549, 554 (9th Cir. 1987); 1965 Code Cong. & Ad. News 1943, 2018.

trust instrument clearly indicates that its resources are intended to supplement rather than to supplant public assistance to Barker.[46] The trust, created for the primary purpose of providing nonmedical support and containing a provision allowing the trustee discretion to provide medical care if the beneficiary ceases to qualify for medical assistance programs, is not an "available resource" under 42 U.S.C. §1396a(17)(B) (Supp. 1990) or a "liquid resource in hand" within the meaning of DHS Manual §1063.212 (11/1/86) for medical assistance eligibility purposes. The medical assistance case is reinstated from

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[46]Miller v. Ibarra, see note 22 at 27, supra; Lang v. Commonwealth, see note 22 at 1345, supra; Zoeli v. Commissioner of Social Serv., see note 30 at 556, supra; Lineback v. Stout, see note 30 at 108, supra; Tidrow v. Director, see note 30 at 14; Hoelzer v. Blum, see note 30 at 690, supra.

the date of termination subject to recertification as provided by the applicable program regulations.

**CERTIORARI PREVIOUSLY GRANTED; OPINION OF THE COURT OF APPEALS VACATED; TRIAL COURT AFFIRMED.**

CONCUR: Hodges, V.C.J., Simms, Doolin, Kauger, Summers, JJ.

CONCUR IN RESULT: Wilson, J.

DISSENT: Opala, C.J., Hargrave, J.

NOT PARTICIPATING: Lavender, J.

Supreme Court, U.S.
FILED
JUN 24 1992
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(3)

No. 91-1946

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1992

STATE OF OKLAHOMA ex rel.
DEPARTMENT OF HUMAN SERVICES,

Petitioner,

v.

TRUST COMPANY OF OKLAHOMA, guardian
of the estate of Ellen Lee Barker,
a minor child,

Respondent.

**BRIEF IN OPPOSITION**

**TO PETITION FOR CERTIORARI**

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Attorney for Respondent,
Trust Company of Oklahoma,
guardian of the estate of
Ellen Lee Barker, a minor
child

## QUESTIONS PRESENTED FOR REVIEW

1. Whether a trust, created for the primary purpose of providing non-medical support but allowing for the payment of medical care if the beneficiary became ineligible for medical assistance, is an "available resource" under the Medicaid Act, 42 U.S.C. §1396a(a)(17)(B).

2. Whether the grantor of a trust may specifically exclude assets of a trust from consideration by a state as a "resource" under the Medicaid Act, 42 U.S.C. §1396a (a)(17)(B) and whether state law controls the definition of "resources" under the Medicaid Act.

3. Whether the Petitioner timely raised Supremacy Clause issue during the state court appellate process as required by Oklahoma Rule 1.16 of Rules of Appellate Procedure in Civil Case.

4. Whether the application of the Oklahoma Supreme Court's state procedural waiver rule improperly precluded the application of federal law in considering the income from a state-created trust in the determination of Medicaid eligibility under 42 U.S.C §1396a(a)(17)(B).

5. Whether an inter vivos trust agreement between a tortfeasor and the guardian of the estate of a minor child constitutes a "Medicaid Qualifying Trust" under the terms of Medicaid Act, 42 U.S.C. §1396a(k)(2).

6. Whether the actions of the Petitioner estopped it from asserting the Trust was an "available resource."

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A. THE PETITIONER DID NOT TIMELY RAISE THE FEDERAL CONSTITUTIONAL CLAIM IN THE COURT BELOW.

B. ANY VARIATION IN INTERPRETATION OF THE FEDERAL STATUTE WHICH RELATES TO WHETHER A TRUST IS AN AVAILABLE RESOURCE HAS OCCURRED BECAUSE EACH CASE VARIES AS TO FACTS.

C. IF THE SUPREMACY CLAUSE WAS TIMELY RAISED IN THE COURT BELOW, THEN THERE IS NOT CONFLICT BETWEEN STATE TRUST LAW AND THE FEDERAL STATUTE.

D. THE PETITIONER'S ACTIONS SHOULD ESTOP IT FROM ASSERTING THE TRUST IS AN AVAILABLE RESOURCE.

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a minor child,

Respondent.

**BRIEF IN OPPOSITION**
**TO PETITION FOR CERTIORARI**

OPINIONS DELIVERED IN THE COURTS BELOW

The opinion set forth in the Petition for Writ of Certiorari is accurate.

GROUNDS UPON WHICH JURISDICTION IS INVOKED

Jurisdiction would be invoked as set forth in the Petition for Writ of Certiorari.

## CONSTITUTIONAL AND STATUTORY PROVISIONS

Petitioner's Appendix II cites Oklahoma Department of Human Services hereinafter referred to as "DHS") Regulation 1062.9 - 1063.211. The text of the Appendix actually includes Regulation 1063.212. For the purpose of explaining this scrivener's error, Respondent's Appendix I sets forth the text of Regulation 1063.212. In addition Appendix I contains Oklahoma Department of Human Services Regulation 1022.23. Appendix II is Oklahoma Rule 1.16 of the Rules of Appellate Procedure in Civil Cases.

## STATEMENT OF CASE

Ellen Barker was four years old when she was injured in a vehicle accident in Arizona on September 20, 1980. The car in which she was riding collided with a school bus operated by Gando Public School District

No. 19, Apache County, Arizona ("Apache School District") and as a result she was rendered a quadriplegic. At the time of her injury she was eligible and therefore was provided medical assistance by DHS.

Within the first six months following her injury, DHS provided $160,000.00 in medical assistance to Ellen Barker. DHS was aware that she was pursuing a claim for her personal injuries and Herbert Hyde, its attorney, filed a lien in Apache County, Arizona, the county where the collision occurred.

Ellen Barker's Arizona attorney wanted to settle her personal injury claim for a sum that would provide for Ellen Barker's medical as well as other needs for the remainder of her life, but such settlement would have been $5,000,000.00 to $7,000,000.00. Such sum was not offered to settle the claim and the Apache School

District would have pursued the case through a trial. Ellen Barker's attorney told Mr. Hyde that the Arizona judge who would be assigned the case would not approve the settlement if the amount was not adequate to pay Ellen Barker's past and future medical expense her permanent disability, pain and all other damages Ellen Barker had sustained. If the case were to be settled, all parties, including DHS, would have to compromise.

Mr. Hyde discussed this case with Lloyd Rader, the then Director of DHS, and it was decided that DHS would accept $200,000.00 as full settlement of Ellen Barker's medical damages. The balance of the settlement would be placed in a discretionary trust for Ellen Barker's non-medical damages.

DHS's acceptance of $200,000.00 formed a basis for the settlement of her claims against the Apache School District. The

Arizona judge approved the settlement, authorized the disbursement of attorney's fees and payment to DHS of $200,000.00. The remaining $818,940.00 was paid to Trust Company of Oklahoma (hereinafter referred to as "Trust Company") to be held pursuant to the Trust Agreement reviewed and approved by the Arizona Judge. Apache School District was the settlor of the trust. Both the purpose clause and powers clause contained in the Trust Agreement make it clear the funds are to be used for Ellen Barker's non-medical needs. Trust Company was also appointed guardian of the estate of Ellen Barker. The guardianship and Trust Agreement were also approved by the District Court of Oklahoma County, State of Oklahoma.

It is not only clear in the Trust Agreement but in the Order Approving Settlement, that it was contemplated by the settlor that the trust funds would be used

solely at the discretion of the trustee for Ellen Barker's non-medical needs. Ellen Barker cannot compel the trustee to distribute funds to her.

An applicant for medical assistance under both Title XIX and CCP regulations is denied eligibility if the applicant has an "available resource" for payment of the applicant's own medical expense. From May of 1981 until June 30, 1987, DHS recertified Ellen every six months and the trust was not treated as an available resource. In 1987, DHS reversed its position and denied future medical assistance to Ellen Barker.

Trust Company appealed the decision through the DHS administrative process but the decision to terminate the assistance was sustained. Trust Company then appealed to the state district court (hereinafter referred to as "trial court") which reversed the decision of DHS. DHS then appealed to

the Oklahoma Supreme Court by filing its petition in error, a copy of which is Appendix III.

The Supreme Court of Oklahoma assigned the case to one of the Oklahoma Court of Appeals which reversed the trial court. Trust Company petitioned for rehearing but that was denied. Trust Company then filed its petition for certiorari with the Supreme Court of Oklahoma which granted the petition, reversed the Court of Appeals and affirmed the trial court. DHS petitioned the Oklahoma Supreme Court for rehearing which was denied. It was at this stage DHS first raised the Supremacy Clause argument.

## SUMMARY OF ARGUMENT FOR DENYING THE WRIT

The Oklahoma Supreme Court was not presented a constitutional issue and hence this court should decline certiorari.

Whether a trust is an available resource depends upon a case by case analysis. A decision by this court will not further a uniformity of law but will only determine this issue for this isolated case. The state court below has reached a fair decision based upon the facts and such decision should not be further reviewed.

A. THE PETITIONER DID NOT TIMELY RAISE THE FEDERAL CONSTITUTIONAL CLAIM IN THE COURT BELOW.

In Oklahoma, an appeal from a trial court is perfected by filing a petition in error pursuant to Rule 1.16 of Rules of Appellate Procedure in Civil Cases. The precise points of law to be urged as error must be set forth in the petition in error. Error that is argued in a brief but not set forth in the petition in error will not be considered on appeal. Barber v. Flynn, 628 P.2d 1151 (Okl., 1980).

The Petitioner commenced the original appeal by filing its Petition in Error which is set forth in the Appendix III to this Brief. The errors raised do not complain that the Supremacy Clause of the United States Constitution was violated. As Petitioner points out in its Appendix III, this case was initially decided by the Court of Appeals in favor of Petitioner. Trust Company petitioned the Supreme Court of Oklahoma for certiorari. Before certiorari was granted, Petitioner filed its response without raising the Supremacy Clause issue. Once certiorari had been accepted, the Court of Appeals decision reversed and the trial court's decision reinstated, the Petitioner filed its Petitioner for Rehearing. It was at this stage that the Supremacy Clause of the United States Constitution was raised. Without written opinion, the Supreme Court of Oklahoma denied the Petition for

Rehearing. This Court should decline to rule on federal constitutional claims not properly perfected and decided by the Supreme Court of Oklahoma. Bankers Life & Casualty Co. v. Crenshaw, 486 U.S. 71, 108 S.Ct 1645, 100 L.Ed.2d 62 (1988).

B. ANY VARIATION IN INTERPRETATION OF THE FEDERAL STATUTE WHICH RELATES TO WHETHER A TRUST IS AN AVAILABLE RESOURCE HAS OCCURRED BECAUSE EACH CASE VARIES AS TO FACTS.

The Petitioner argues that this court should accept certiorari and decide once and for all whether a trust is an available resource under 42 U.S.C. §1396a(a)(17)(B). One must presume this means one rule for all trusts and not decisions on a case-by-case basis. This is not practical because of the wide variation in the factual situations. Perhaps the Secretary foresaw this problem and hence the reason for a general and not a specific definition.

A review of the cases illustrate divergent facts presented to court across the country. In Barham by Barham v. Rubin, 816 P.2d 965 (Hawaii 1991) a tort claim was settled for $310,000 in cash and an annuity of $3,000 a month for life. A Colorado probate court, as settlor, created a trust for Phillip W. Barham. The court held this to be a "medicaid qualifying trust" (MQT) under 42 U.S.C. 1396a(k)(2) which rendered him ineligible for public assistance.

In some states damages awarded a minor in a tort claim must be placed in a restricted bank account which may only be withdrawn with a court order. Arkansas Department of Human Services v. Donis, 280 Ark. 169, 655 S.W.2d 452 (Ark. 1983) and In the Matter of Welfare of K. S., 427 N.W.2d 653 (Minn. 1988) have both held such bank accounts to be available resources.

Other cases have dealt with testamentary trusts. Lang v. Commonwealth, Department of Welfare, 515 Pa. 428, 528 A.2d 1335 (Pa. 1987), Hoelzer v. Blum, 462 N.Y.S.2d 684, 93 A.D.2d 605 (N.Y.App.Div. 1983), Chenot v. Bordeleau, 561 A.2d 891 (R.I. 1989), Lineback v. Stout, 79 N.C.App. 292, 339 S.E.2d 103 (1986), Tidrow v. Director, 688 S.W.2d 9 (Mo.Ct.App. 1985). Each of these trusts had its own unique wording which each court interpreted in making its decision that the trust was not an available resource. In Miller v. Ibarra, 746 F.Supp. 19 (D.Colo.1990), the court held that trusts created by the district court for severely disabled persons were not available resources. The settlor was not the beneficiary of the trust.

The variation in the facts in each case is the reason for the differences in decisions. If this Court accepts certiorari

and affirms or reverses the Oklahoma Supreme Court it will not settle this issue once and for all. The Petitioner believes that this Court can unify these decisions thus creating a single rule which will apply to all trusts. This is not a workable solution to an issue which requires flexibility. Accepting certiorari will not serve the purpose which Petitioner desires but will only decide the application of 42 U.S.C. §1396 to this particular fact situation.

C. IF THE SUPREMACY CLAUSE WAS TIMELY RAISED IN THE COURT BELOW, THEN THERE IS NOT CONFLICT BETWEEN STATE TRUST LAW AND THE FEDERAL STATUTE.

The Petitioner argues there is a conflict between 42 U.S.C. §1396a(a)(17)(B) and the Oklahoma Trust law defined by the court below. Since the federal statute only generally provides for taking into account ". . . income and resources as determined in

accordance with the standards prescribed by the Secretary, available to the applicant or recipient. . ." and the state plan does not define this trust as an available resource, the Petitioner can only argue what Congress must have meant in adopting the federal statute. The other argument is that Congress expressed its intent that the Barker trust was an available resource when it adopted the Medicaid Qualifying Trust legislation. It seems obvious the intent of that legislation was to prevent healthy persons with assets from creating their own trust to allow them eligibility for medical benefits.

State rules should not be overridden by federal courts unless there is "clear and substantial" federal interest being damaged. United States v. Yazell, 382 U.S. 341, 86 S.Ct. 500, 15 L.Ed. 404 (1966). There is no clear, direct conflict between federal

statutes and the Oklahoma Supreme Court ruling, only a conflict with the perceived intent of the legislation. The Supremacy Clause is not applicable here.

D. THE PETITIONER'S ACTIONS SHOULD ESTOP IT FROM ASSERTING THE TRUST IS AN AVAILABLE RESOURCE.

The Petitioner was an active participant in the settlement of Ellen Barker's tort claim. A DHS attorney signed a court order approving the Trust Agreement and disbursing $200,000 to it for medical expenses. Ellen Barker continued to receive medical assistance from DHS until June 30, 1987, when it decided that the trust was an available resource.

The trial court found that the actions of DHS estopped it from claiming the trust to be an available resource. The Oklahoma Court of Appeals reversed the trial court on the issue of estoppel without deciding the

available resource question. The Supreme Court of Oklahoma made mention of the estoppel question, but declined to rule because it found that the trust was not an available resource.

Although the general rule is that estoppel does not apply against the government, the Supreme Court of Oklahoma has made an exception where a prevailing public interest exists. Burdick v. Independent School District No. 52, 702 P.2d 48 (Okl. 1985).

It is unfair that Ellen Barker relied upon DHS in settling her tort claim only to find out later that it is reversing its position. The harm cannot be reversed. Estoppel should apply.

## CONCLUSION

This case presents no constitutional question for review. The only issue is

whether the state court ruling violates the perceived intent of a federal statute. The Petitioner asks this Court to accept certiorari and establish a rule that will be applicable to all trusts. This is not a practical solution. Perhaps the Secretary has not attempted to further define which trusts are available resources because of the difficulty in predicting the facts of future cases. The Petitioner admits in its brief that there are few applicants for benefits who are beneficiaries of trusts. This is not an important issue for this Court to decide. Certiorari should be denied so that the determination of whether a trust is an available resource will remain flexible and decided on a case by case basis.

Respectfully submitted,

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(4)

No. 91-1946

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1992

STATE OF OKLAHOMA, ex rel.
DEPARTMENT OF HUMAN SERVICES,

Petitioner,

v.

TRUST COMPANY OF OKLAHOMA,
guardian of the estate of Ellen Lee Barker,
a minor child,

Respondent.

On Petition for Writ of Certiorari to the
Supreme Court of Oklahoma

# MOTION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE AND BRIEF OF THE STATES OF MISSOURI, MONTANA, AND NEBRASKA, AS AMICI CURIAE IN SUPPORT OF PETITIONER


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MOTION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE

Amici hereby respectfully move for leave to file the attached brief amicus curiae in support of petitioner in this case. The consent of the attorney for the petitioner has been obtained. The consent of the attorney for the respondent was requested but refused.

The interest of amici in this case, as described in detail in the attached brief, arises from the fact that, like petitioner, amici are states that seek to save millions of Medicaid dollars per year by counting as assets (for Medicaid eligibility purposes) personal injury lawsuit settlement trusts. The Oklahoma Supreme Court decision below interpreted the Medicaid Act to forbid a state from counting such trusts as assets. The Oklahoma court's rule effectively allows tortfeasors, by configuring their settlements as trusts, to pass on much of the cost of the injuries they cause to state and federal taxpayers. Amici are all states for which the

law is, at worst, the same as in Oklahoma or, at best, unsettled.

Petitioner argues that the Medicaid Act allows the state to count various other kinds of trusts in addition to personal injury settlement trusts. Amici support petitioner in this broader argument but focus on the particularly erroneous nature -- in terms of both law and policy -- of the Oklahoma court's decision in the personal injury settlement trust context. Amici feel that the Court will be aided by the presentation of a narrower perspective on the issues in this case.

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July 1, 1992

BRIEF OF THE STATES OF
MISSOURI, MONTANA, AND NEBRASKA,
AS AMICI CURIAE IN SUPPORT OF PETITIONER

## QUESTION PRESENTED

1. Whether the Medicaid Act permits states, in making eligibility determinations, to count as an "available resource" any trust that is established as part of a negotiated personal injury lawsuit settlement but that contains a provision that the trust is not to be used to pay the medical costs of the injury (unless public assistance is terminated).

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## INTEREST OF THE AMICI CURIAE

Amici are states that participate in federal matching fund programs authorized by the Social Security Act, including Medicaid (Title XIX). Serious personal injury accidents caused by negligent tortfeasors and involving victims of modest means, such as the accident in this case, occur frequently in these states. States have various ways of ensuring that such tortfeasors, rather than Medicaid, ultimately pay the medical expenses of the injuries they cause. The Medicaid Act, in fact, requires states to make all reasonable efforts to pursue payment from responsible tortfeasors.[1/]

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[1/] See 42 U.S.C. § 1396a(25) (Supp. 1990) (requiring states to "take all reasonable measures to ascertain the legal liability of third parties" and to "seek reimbursement . . . to the extent of such liability"). See generally Deborah Tussey, Annotation, Personal Injury Recovery as Effecting Eligibility For, or Duty to Reimburse, Public Welfare Assistance, 80 A.L.R. 3d 772 (1977 & Supp. 1991).

Specifically, states typically pay the victim's high medical costs as they are incurred and then seek reimbursement if there is a responsible tortfeasor. Reimbursement is pursued either directly, by suing the tortfeasor on behalf of the victim, or indirectly, by recovering the medical costs from any money judgment or settlement that the victim has secured. If and when the victim recovers, all future medical expenses are paid from the judgment or settlement funds, not from Medicaid funds (at least until the amount of the judgment or settlement apportioned for medical expenses is dissipated). To require otherwise -- that is, to require Medicaid to pay in addition to the tortfeasor -- is to allow the victim double recovery.

The policy of making liable tortfeasors, rather than Medicaid, ultimately pay for the injuries they cause avoids unnecessary expenditures of taxpayer money.

The Health Care Financing Administration ("HCFA"), the agency that administers the Medicaid Act, estimates that the presence of liable third parties -- including tortfeasors -- saves the Medicaid system over a billion dollars of state and federal funds per year.[2/]

The regrettable consequence of the Oklahoma Supreme Court's interpretation of the Medicaid Act in this case is to limit drastically the Medicaid system's ability to take financial advantage of the presence of responsible tortfeasors. Specifically, the decision effectively prohibits Oklahoma from collecting medical cost reimbursements (or from denying additional claims after recovery) in any situation in which the tortfeasor and the victim negotiate a settlement in the form of a trust and include in the trust a

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[2/] **Senate Comm. on Energy and Commerce, 100th Cong., 2d Sess., Medicaid Source Book: Background Data and Analysis** 146 (Comm. Print 1988).

provision that the funds not be used for any medical expenses unless public assistance is terminated -- what may be called a "qualified no-medical-expenses provision." Because under the Oklahoma's decision it is always to both parties' advantage to negotiate such a trust,[3/] valuable Medicaid resources will be increasingly diverted as more and more tort settlements are configured this way. At a time of severe pressure on state and federal budgets and of growing demand for government-financed health care for the truly indigent, the financial implications of the Oklahoma Supreme Court decision are particularly acute.

Though this brief focuses on personal injury settlement trusts, the interest of amici extends -- as does

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[3/]This is because the tortfeasor saves having to pay any of the victim's medical expenses and can pass on some of the savings to the victim as an inducement for her to agree to a settlement trust with a qualified no-medical-expenses provision. The victim's medical expenses are paid either way.

petitioner's interest -- to all trusts that include qualified no-medical-expenses provisions, such as various kinds of testamentary trusts. Viewed from this more general perspective, the financial consequences of the Oklahoma Supreme Court's are even more severe. The decision effectively forces states to provide valuable Medicaid funds to large numbers of relatively well-off people who, were their assets not in the form of a trust, would be ineligible.

This case presents the Supreme Court its first opportunity to decide whether the Medicaid statute forbids states, in determining Medicaid eligibility, from counting as assets trusts with qualified no-medical-expenses provisions. The state courts are divided, including over the particular issue of personal injury settlement trusts. Given what is at stake in having the relevant Medicaid provisions properly and uniformly

interpreted, amici strongly urge the Court to accept Oklahoma's petition for a writ of certiorari.

## SUMMARY OF FACTS

As recounted at length in the Oklahoma Supreme Court decision and in petitioner's brief, a schoolbus struck Ellen Lee Barker causing her permanent paralysis from the neck down. Because at the time her family had few resources, the Oklahoma Department of Human Services ("DHS") paid the approximately $160,000 in medical expenses that Ellen quickly incurred after the accident. Ellen's mother sued the school district that operated the bus for compensatory damages including all past and future medical expenses arising from the injury (as well as future lost wages and "pain and suffering" damages).

After negotiations, the school district and Ellen's mother eventually settled the claim for $1.35 million. DHS was reimbursed from this sum for its past medical

expenditures on Ellen's behalf.[4/] As required by Oklahoma law in cases involving minors, the school district put the remaining funds in a trust naming Ellen Lee Barker as beneficiary rather than make a direct cash payment.

In pertinent part, the trust agreement stated that "Ellen's medical needs have been provided for by the Oklahoma Department of Human Services."[5/] In addition, the language assumed that DHS would continue to pay such medical needs. On this assumption, the trust went on to say that its funds should generally not be used for ongoing

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[4/]Respondents have argued that by accepting reimbursement for past medical expenses, DHS was estopped from denying eligibility for ongoing and future medical expenses, partly because a DHS employee made some unauthorized representations to that effect during settlement. Because it held that the Medicaid Act does not allow states to count settlement trusts as assets, the Oklahoma Supreme Court did not need to reach the estoppel issue.

[5/]Trust Company of Oklahoma v. State of Oklahoma, ex rel. Dep't of Human Services, 825 P.2d 1295, 1296 n.2 (Okla. 1991) (reprinting excerpts of the trust agreement).

medical expenses but rather for expenses related to lost wages and "pain and suffering" -- i.e., those things that will "assure her of as natural and pleasant a life as is possible in her condition."[6/] Medical expenses would be paid only in the event that public assistance was terminated.

Because the value of the trust far exceeded Oklahoma's limit on the assets that Medicaid recipients may have, DHS eventually terminated its payments for Ellen's ongoing medical expenses. Litigation ensued over the termination. Ultimately the Oklahoma Supreme Court decided that the state could not count the negotiated trust as an asset in determining Ellen's eligibility.

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[6/] Id. at 1296 - 97 n.2.

## SUMMARY OF ARGUMENT

This case presents an important issue of federal law, one with enormous financial implications for the states and federal government and over which the state courts are split. The particular issue is whether the Medicaid Act permits states, in making eligibility determinations, to count as an asset a trust whose creators did not want it to be used for medical services. The Oklahoma Supreme Court ruled that the Medicaid Act requires states to honor the intent of the trust's creators.

This brief focuses on the particularly erroneous nature of the Oklahoma court's ruling as applied to personal injury settlement trusts -- a unique but important kind of trust. In short, the Oklahoma Supreme Court's interpretation of the relevant Medicaid provisions as applied to these trusts

fails to comport both with the plain meaning of the provisions and the legislative intent behind them. It is also inconsistent with an advisory letter that the Health Care Financing Administration, the agency in charge of administering Medicaid, recently sent to Oklahoma stating that personal injury settlement trusts do count as assets.

Equally important are the extreme financial consequences of the Oklahoma's decision -- a decision which effectively forces states to allow tortfeasors to pass on to the Medicaid system the medical expenses component of their obligation to pay compensatory damages. Such a rule diverts state and federal Medicaid funds away from indigent people who do not have legal entitlement to any other medical funding source. It also allows tortfeasors to pay much less in a settlement than state tort law would otherwise require, simply by configuring

the settlement as a trust. Finally, the rule adopted by the Oklahoma Supreme Court is wholly inconsistent with Congress's mandate to take financial advantage of responsible tortfeasors. A state that is forced to pay medical expenses that tortfeasors ought to be paying can not be said to be fulfilling this mandate.

## ARGUMENT

### I. THE COURT SHOULD REVIEW THE OKLAHOMA SUPREME COURT'S INTERPRETATION OF THE MEDICAID ACT THAT PROHIBITS A STATE, IN MAKING ELIGIBILITY DETERMINATIONS, FROM COUNTING PERSONAL INJURY LAWSUIT SETTLEMENT TRUSTS AS "AVAILABLE RESOURCES"

#### A. The Court Should Correct the Oklahoma Supreme Court's Misinterpretation of § 1396a(k) as Applied to Negotiated Personal Injury Settlement Trusts

In 1965, Congress passed the Medicaid Act, a federal matching-fund program designed to provide health care to the truly needy.[7/] States are required to establish reasonable maximum income and resource (i.e.,

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[7/] See 42 U.S.C. § 1396 (Supp. 1990) (stating that Medicaid is designed for "families with dependent children and [] aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services"); see also Atkins v. Rivera, 477 U.S. 154, 156 (1986); Schweiker v. Gray Panthers, 453 U.S. 34, 36 (1981); Harris v. McRae, 448 U.S. 297, 301 (1980) (stating that Medicaid is designed to help states pay the medical expenses of "needy persons").

asset) limits to ensure that only the truly needy receive Medicaid funds.[8/]

Individuals who otherwise would have been ineligible for Medicaid eventually began evading the resource limits by putting their assets into trusts that contained provisions that they were not to be used for medical purposes unless public assistance was terminated. Such trusts, these individuals presumably would have argued, were not "available" to the beneficiary under the general Medicaid provision, 42 U.S.C. §

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[8/] See 42 U.S.C. § 1396a(17) (Supp. 1990).

1396a(17)(B),[9/] and thus could not have been counted towards eligibility.

In 1986, Congress responded by passing an amendment to the Act, the "Medicaid Qualifying Trust" provision, 42 U.S.C. § 1396a(k), generally designed to prevent otherwise ineligible individuals from evading resource limits through the use of trusts with qualified no-medical expenses provisions. Specifically, the provision requires states to "deem[] available . . . for purposes of subsection (a)(17)" any inter vivos,

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[9/] 42 U.S.C. § 1396a (Supp. 1990) provides in pertinent part,

> A State plan for medical assistance must . . . (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . .

discretionary trust in which the same "individual" who "establishe[s]" the trust is also the named beneficiary -- a Medicaid Qualifying Trust ("MQT") -- regardless of whether the trust contains a qualified no-medical-expenses provision.[10/] Spouses are considered interchangeable for the purposes of a MQT. Significantly, in explaining the provision, the House Committee Report invoked the Medicaid Act's original purpose:

> The committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves.[11/]

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[10/] 42 U.S.C. § 1396a(k) (Supp. 1990).

[11/] H.R. Rep. No. 265, 99th Cong., 1st Sess. 72 (1986). The Report continues, "When affluent individuals use Medicaid qualifying trusts and similar 'techniques' to qualify for the program, they are diverting scarce Federal and State resources from low-income elderly and disabled individuals, and poor women and children. This is unacceptable to the Committee." It is worth noting that the text of the statute does not use the term

(continued...)

While there is a strong argument that § 1396a(k) -- or at least the more general provision, § 1396(17)(B) -- should be read to deem "available" any trust with a qualified no-medical-expenses provision, even if not literally established by the beneficiary (or her spouse or guardian[12/]), it is indisputable that § 1396a(k)'s definition of a MQT covers personal injury settlement trusts that victims negotiate for themselves.[13/] The Oklahoma Supreme Court's finding (in a footnote) that such trusts are

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[11/](...continued)
"affluent." Any individual who would be ineligible for Medicaid but for having set up an asset-shielding trust is covered.

[12/]See State Medicaid Manual, HCFA-Pub 45-3, Transmittal No. 37 (May 1989) (stating that for the purposes of § 1396a(k), an individual and her legal guardian should be treated as the same person); see also Hatcher v. Dep't of Health and Rehabilitative Services, 545 So.2d 400 (Fla. Dist. Ct. App. 1989).

[13/]See infra note 26 and accompanying text (discussing cases involving trusts other than personal injury settlement trusts).

not MQTs assumed that tortfeasors are the sole creators of settlement trusts and thus that victims can not be said to "establish[]" such trusts on their own behalf. The court summarily asserted that "[h]ere, the settlor [i.e., the creator of the trust] is not the beneficiary . . . but the tortfeasor."[14/]

The Oklahoma Supreme Court's position overlooks the crucial fact that personal injury settlement trusts are not unilaterally-created instruments like the typical donative trust. They are the product of contractually negotiated agreements that require two parties' assent. It takes two parties to establish any given settlement trust, and thus both parties should be deemed its creators. To be sure, the tortfeasor is often the offeror in settlement negotiations and the victim the offeree. Nevertheless,

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[14/] Trust Company of Oklahoma v. State of Oklahoma, ex rel. Dep't of Human Services, 825 P.2d 1295, 1302 n.31 (Okla. 1991).

under the most basic principles of contract law, once a valid settlement contract is formed, such distinctions become irrelevant.

This contract law argument is not meant to be formalistic. When an accident victim (or her guardian) negotiates and assents to, as Ellen's mother did here, a settlement trust that includes a qualified no-medical-expenses provision, all the while recognizing that if the money were paid directly the victim would be ineligible for Medicaid, the victim is taking an action on behalf of herself to evade Medicaid eligibility requirements. Preventing such evasion goes to the core of the purpose behind § 1396a(k), even under its narrowest construction.

Subsequent to the decision below, the Health Care Financing Administration ("HCFA"), the agency within the Department of Health and Human Services charged with

administering the Medicaid statute, recently advised Oklahoma that personal injury settlement trusts are indeed MQTs.[15/] Specifically, HCFA explained that "the State should consider such trusts as Medicaid Qualifying Trusts and count the funds as fully available."[16/] HCFA's position is consistent with its earlier opinions that the MQT provision should not be construed too literalistically.[17/] Because Congress

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[15/]Letter from Don Hearn, Chief of Program Operations Branch for Medicaid, HCFA to Charles Brodt, Assistant Director for Medical Services, Oklahoma Department of Human Services (March 12, 1992) (lodged as Appendix I). HCFA has not as yet issued any regulations directly on the question of whether trusts should count as "available resources" under Medicaid.

[16/]Id.

[17/]See State Medicaid Manual, HCFA-Pub 45-3, Transmittal No. 37 (May 1989) (stating that for the purposes of § 1396a(k), an individual and her legal guardian should be treated as same person); see also Hatcher v. Dep't of Health and Rehabilitative Services, 545 So.2d 400 (Fla. Dist. Ct. App. 1989). In the absence of guidance from HCFA, some courts

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specifically charged HCFA with the responsibility of administering Medicaid, HCFA's interpretation should be accorded

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[17/](...continued)
including the Oklahoma Supreme Court looked to analogous public assistance statutes. For example, the Oklahoma court relied in part on the Supplemental Social Security program ("SSI") regulations that deem "available" any resource that an individual "owns and could convert to cash." See 20 C.F.R. § 416.1201(a); see also 45 C.F.R. § 233.20(a)(3) (stating that for, purposes of the Aid to Families with Dependent Children program, assets are available when "actually available and when the applicant or recipient has a legal interest in the liquidated sum and has the legal ability to make such sum available for support and maintenance"). While the language of this regulation arguably means that trusts with qualified no-medical-expenses provisions are "available," the Social Security Administration has issued an informal manual on SSI eligibility explaining that trusts should not be deemed "available" where "only the trustee or court, etc., can invade the principal." **Social Security Admin., Dept. of Health and Human Services, Program Operations Manual System**, SI 01120.105 A.2 (Oct.1981); see also Alabama Medicaid Agency v. Primo, 579 So.2d 1355 (Ala. Civ. App. 1991) (holding that the SSI manual's standard pertaining to trusts applies to the Medicaid context and that that standard precludes states from counting as an "available resource" testamentary trusts with qualified no-medical-expenses provisions).

significant deference under Chevron.[18/] The inconsistency of the decision below with the HCFA interpretation provides an additional reason for the grant of a writ of certiorari in this case.

**B. The Policy Arguments for Not Allowing States to Count the Typical Donative Trust as an Asset Have no Application to**

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[18/] See Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). One important assumption that HCFA's interpretation confirms -- an assumption expressly shared by both parties in the present case -- is that the question of "available resources" under the Medicaid Act is a question of federal law. See Schweiker v. Gray Panthers, 453 U.S. 34 (1981) (assuming that the interpretation of "available" resources under § 1396a(17)(B) is governed by federal law). While the interpretation of a trust may be governed by state law, which requires inquiry into the intent of the creator, it is indisputable that the question of the extent to which the Medicaid Act honors such intent is a federal one. The few cases that discuss only state trust law are therefore presuming without argument that the federal Medicaid Act -- or state medicaid guidelines passed pursuant to the Act -- does indeed honor the creator's intent. See Lee R. Russ, Annotation, Eligibility for Welfare Benefits as Affected By Claimant's Status as Trust Beneficiary, 21 A.L.R. 4th 729 (1983 & Supp. 1991) (discussing such cases).

**the Negotiated Personal Injury Settlement Trust**

The Oklahoma Supreme Court offered two main arguments for not counting trusts with qualified no-medical-expenses provisions as Medicaid assets -- that is, why the Medicaid Act should honor the evasive intent behind these exclusionary clauses. First, with respect to the creator of such a trust, the court argued that a person "attempting to provide for a handicapped person should not be required to either bankrupt estates [by setting up a trust that would be used for all medical expenses until dissipated] or leave the disadvantaged party to the vagaries of public assistance programs [by deciding not to set up a trust]."[19/] Second, with respect to the beneficiary, the court suggested that it would be unfair to authorize use of the trust

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[19/] See Trust Company of Oklahoma v. State of Oklahoma, ex rel. Dep't of Human Services, 825 P.2d 1295, 1303 (Okla. 1991).

for medical expenses when such authorization would lead to its "rapid and total dissipation."[20/]

While amici question the force of these arguments as applied to the typical donative trust, neither argument has any application to personal injury settlement trusts. First, the dilemma that the Oklahoma Supreme Court wants to avoid -- forcing the trust creator either to set up a trust that will quickly dissipate or to set up no trust at all -- does not exist in the personal injury settlement trust context. The responsible tortfeasor does not have the option of not making any payments at all (whether by trust or by direct payment); state tort law requires him to provide at least some compensation to the victim. That is what it means for him to be a tortfeasor and why he comes to the settlement table in the first

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[20/] Id.

place. Indeed, to the extent compensatory damages include medical expenses, the dissipation of a settlement trust for just this purpose is what state tort law expects to happen. To avoid the trust's dissipation only by forcing Medicaid to pay medical expenses that the tortfeasor ought to have paid unnecessarily shifts the burden of liability from the responsible tortfeasor to the taxpayers.

Second, a rule that prevents tortfeasors from passing the cost of the victim's medical care on to the Medicaid system is not unfair to the victim-beneficiary. Significantly, the victim gets paid either way. Keeping the rule in mind, she should not settle unless the tortfeasor is willing to make the trust fund large enough to pay for such expenses -- or whatever equivalent calculation the injured party would make if the settlement offer involved direct

money payments. If settlement is unsuccessful and she loses the lawsuit, Medicaid will still pay her medical bills.

A rule that allows states to count personal injury lawsuits settlements is not only fair to the parties, but it affirmatively prevents the parties from cheating state and federal taxpayers. Oklahoma's rule effectively allows tortfeasors to pass on to Medicaid that portion of the tortfeasor's damages that goes to medical expenses. No private first-party health insurer would allow a responsible tortfeasor to get away with this, and nor should Medicaid. Even Medicaid itself does not allow tortfeasors to pass the buck when a settlement is paid in the form of a direct cash payment.

### C. This Court Should Resolve the Split Among State Courts With Respect to Personal Injury Settlement Trusts

The two other state high court cases that have specifically addressed the

"availability" of personal injury settlement trusts under the Medicaid statute conflict with the Oklahoma Supreme Court decision. In Barham v. Rubin,[21/] the Supreme Court of Hawaii addressed a judicially-approved personal injury settlement trust that named the incompetent victim as beneficiary. As is true in all these cases, the trustee had discretion to spend the funds in the beneficiary's best interest except that he was not to spend them on medical services unless public assistance was unavailable. The Hawaii high court deemed the victim-beneficiary a creator of the trust. Accordingly, it concluded that under § 1396a(k) the trust is an MQT and thus an "available" resource for Medicaid eligibility purposes.

The court reasoned that allowing someone with this kind of trust fund to collect medical assistance "would violate the

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[21/]816 P.2d 965 (Haw. 1991).

spirit and intent of the medicaid laws."[22/] More specifically, in dismissing the argument that the victim was not a creator of the trust, the court relied on the fact that, at the time the probate court approved the settlement that contained the trust, the underlying assets "already belonged to the beneficiary."[23/] The same could be said of the underlying assets in any personal injury settlement trust. At the moment any such trust is approved by the court and thus formally "established," the beneficiary already effectively owns the legal right to compensatory damages (including medical expenses).

The other court case that directly conflicts with the Oklahoma court decision is Matter of Welfare of K.S.[24/] There, the

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[22/] Id. at 967.

[23/] Id.

[24/] 427 N.W.2d 653 (Minn. 1988).

Minnesota Supreme Court relied mainly on its interpretation of Minnesota's state medicaid eligibility guidelines rather than the federal provisions, § 1396a(17)(B) and § 1396a(k). Still, because the Medicaid Act expressly states that such state medicaid guidelines are valid only so long as they are consistent with federal law,[25/] the Minnesota court's reliance on such guidelines assumes that § 1396a(17)(B) and § 1396a(k) do not prohibit states from counting personal injury settlement trusts as assets.

Finally, there are also conflicts in the state courts over the "availability" of other kinds of trusts for Medicaid eligibility purposes."[26/] That this Court's decision

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[25/]42 U.S.C. §1396a(17)(B) (Supp. 1990).

[26/]For example, consistent with the Oklahoma Supreme Court's restrictive approach, at least three jurisdictions have adopted the rule that the Medicaid Act prohibits states from counting certain testamentary trusts as "available resources. See Alabama Medicaid

(continued...)

could provide additional guidance with respect

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[26/](...continued)
Agency v. Primo, 579 So.2d 1355 (Ala. Civ. App. 1991); Tidrow v. Director, 668 S.W.2d 9 (Mo. Ct. App. 1985); Zeoli v. Comm'r of Social Service, 425 A.2d 553, 559 (Conn. 1979); see also Miller v. Ibarra, 746 F.Supp. 19 (D. Colo. 1990) (involving a judicially-imposed trust designed to protect the assets of mentally incompetent nursing home patients). Because testamentary trusts are by definition not inter vivos, they are not MQTs. Still, petitioner makes the persuasive argument that, even if § 1396a(k) does not require states to count these trusts as assets, § 1396a(17)(B), which is the general "available resource" provision, permits states to count them.

At the same time, consistent with the Hawaii Supreme Court's decision, the Arkansas Supreme Court has ruled that states may count as "available" assets settlement trusts arising out of wrongful death actions. See Arkansas Dep't of Human Services v. Donis, 655 S.W.2d 452 (Ark. 1983).

Finally, it is important to recognize that many of the court decisions involving these other kinds of trusts, especially thoses cited by the Oklahoma Supreme Court in support of its position, rest on state law and so are to that extent inapposite. See, e.g., Chenot v. Bordeleau, 561 A.2d 891 (R.I. 1989); Kline v. Utah Dep't of Health, 776 P.2d 57 (Utah Ct. App. 1989); Lang v. Commonwealth, 528 A.2d 1335 (Pa. 1987); Lineback v. Stout, 339 S.E.2d 103 (Ct. App. N.C. 1986); Hoelzer v. Blum, 462 N.Y.S.2d 684 (N.Y. App. Div. 1983); Jansen v. Department of Public Welfare, 266 N.W.2d 742 (Neb. 1978).

to these other kinds of trusts serves as one more reason the Court should take this case.

## CONCLUSION

For the above reasons, amici urge the Court to accept this case in order to determine uniformly whether the Medicaid Act permits states to count personal injury lawsuit settlement trusts as "available resources."

Respectfully submitted,

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